U.S. DEPARTMENT OF VETERANS AFFAIRS

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VETERANS HEALTH ADMINISTRATION

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INDUSTRY FORUM

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THURSDAY,
FEBRUARY 2, 2006

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The meeting was held in the Regency C Ballroom of the Hyatt Regency Crystal City, 2799 Jefferson Davis Highway, Arlington, Virginia, at 1:00 p.m., C. Mark Loper, Chief Business Officer, presiding.

PRESENT:

JONATHAN B. PERLIN, M.D., Ph.D., MSHA, FACP
Under Secretary for Health

C. MARK LOPER, FACHE, FAHM
Chief Business Officer

CAROL CHIPMAN
Health Administration Center

DENNIS R. MALONEY
Deputy Director for VHA Acquisitions

LEONARD NALE

Chief Business Office Contracts Manager

C-O-N-T-E-N-T-S

P-R-O-C-E-E-D-I-N-G-S

(1:09 p.m.)

MR. LOPER: Good afternoon, ladies and gentlemen. I'm Mark Loper. I'm the chief business officer for the Veterans Health Administration. And I'm pleased to welcome you here this afternoon, and very pleased to be joined by Dr. John Perlin, our Under Secretary for Health, in what is the first opportunity to engage with industry on behalf of a very robust and important program for the department.

Nominally in response to recent appropriations act legislation, it has been referred to as contract care and coordination. And we will go through in some detail the language in the law, and some of the general parameters of our intentions in satisfying those requirements, and look forward to that and whatever exchange we might have.

This is principally an introduction to industry and academia in fact about the Department's response to the law, the scope, nature, desires, impact, and so forth. And we look forward to discussing with you.

Going forward we anticipate subsequent meetings as well. So the law having been passed right at the end of November, I think I tend to

believe we got to about a 10 percent design of our approach by the end of December. And I think, I'm pleased to say, we're about a 20 percent design. But that leaves about 80 percent yet to be definitized. And I think much to the credit of the undertaking it is to include, as you will hear numerous statements throughout this, to be a collaborative effort between the Department and private and public sectors to develop the best solutions for veterans.

And so I welcome you here certainly on our behalf, and more importantly, your expressions of interest in support of veterans by your presence here today.

So with that I'd just like to outline the agenda for this session, and welcome you all.

We will be listening to Dr. Perlin who is going to keynote, and share important perspectives about VA and the things we need to be mindful of and aware of as we contemplate our future course of action.

I will then undertake to enumerate that 20 percent design if you will that we have come to at this point, and set the stage for going forward.

We will then be informed by our acquisition committee about the nature of any

conflicts, or any completed solicitation that would flow from this.

And then actually anticipating a period of time for questions, particularly regarding the procurement process, scope and approach. And we have retained an entity to assist the department in that procurement process, actually, Acquisition Solutions, Incorporated. They have substantial experience in this regard, and I think they bring a very exciting performance-based model to the procurement that we would undertake.

So with that, I'd like to introduce Dr. Perlin. And I'll take a little bit of license to have a somewhat extended introduction here, in fact because there is a lot of information relevant to this matter.

The Honorable Dr. Jonathan B. Perlin was nominated by President Bush to serve as the undersecretary for the Department of Veterans Affairs in February, 2005, and confirmed later by the Senate in April, 2005. He had previously served as the acting undersecretary since April, 2004.

As the chief executive officer for the Veterans Health Administration, Dr. Perlin leads the largest integrated health system in America.

With more than 7.6 million veterans enrolled, the VHA provides health care to more than 5.3 million veterans each year throughout the United States and many of its territories.

The VHA operates on a medical care budget of over $30 billion, and directly employs nearly 200,000 health professions at more than 1,300 sites of care.

The VA is recognized, as many of you, as a leader in clinical informatics and performance improvement, and is setting national benchmarks in patient satisfaction, and in 18 indicators of care and disease prevention and treatment.

Importantly, in addition to its medical mission, VHA is the largest provider of graduate medical education, and a major contributor to medical and scientific research. More than 150,000 volunteers and 90,000 health professions trainees, and 25,000 affiliated medical faculty are also integral to the VHA community. So this is clearly a substantial enterprise.

In December, 2005, he was named a commissioner of the American Health Information Community, chartered by the Secretary of the Department of HHS to support the president's goal in

making electronic health records for most Americans within 10 years. And he presently serves as the elected president of the Association of Military Surgeons in the United States.

He has served in various capacities within the department, including Deputy Under Secretary for health, acting chief research and development officer, chief quality performance officer. And has the responsibility to lead the VA to be one of two federal agencies recognized twice by Congress for managing for results.

He's a follow of the American College of Physicians; holds a master's degree in health administration; received his Ph.D. in pharmacology and toxicology, with his MD as part of the medical scientist training program at Virginia Commonwealth University's Medical College in Virginia.

We are pleased and honored and frankly I very much look forward to the remarks that Dr. Perlin will share with us today.

Dr. Perlin.

(Applause)

DR. PERLIN: Well, good afternoon.

It's a delight to see so many people here and interested in this activity. Particularly I

appreciate seeing our friends from veterans service organizations. Particularly at this time of year, we think about and thank you all for your support, and thank colleagues from the health care industry who join us today. I appreciate the opportunity for us all to get together.

I want to really divide my comments this afternoon into two sets. One is really talking a little bit about VA's transformation over the past decade. I think that is important, if we are going to do some work together, I think it's important that we sort of get an understanding of today's VA.

I know there are some of you in this room who know VA as well as the people within VA. For others, I think it may be an opportunity to learn that we are not your father's VA. We're a remarkably changed organization.

You may think that is hyperbole, and that is a fair challenge. But I think I'd be interested in your thoughts after we take a look at the data of transformation and some of the things that have occurred over the past decade.

I'd note that as we enter this debate about how we might work together, I should really identify that there are four reasons that VA will

purchase care. One is access; another is capacity; a third is proficiency and technology; and a fourth is efficiency.

So access when care is not available in a particular region, or there are particular challenges, that may be a particular situation.

Capacity, this is something that is probably self explanatory.

Proficiency and technology, when there is some service that is not one we make.

Efficiency is extremely rare, and I'll show you exactly why in terms of the ability of VA to produce high quality care very, very efficiently, VA is generally most efficient.

And there are three things that I am emphasizing. One, the transformation of VA, not your father's VA. The second, why VA would purchase services. The third, if that second one suggests that there is really a somewhat limited spectrum as to why VA would purchase service. Why would you want to partner with us? Why if part of the thrust of this demonstration is to improve the consistency and our efficiency of our care purchasing would VA in fact be a fabulous business partner.

So I want to talk about first the

transformation of VA health care. It's an incredible story.

You heard me say that we are not your father's VA, but increasingly, in both the professional and lay press, this is an increasingly widely held view. Some of you may have seen an article in last week's New York Times, other articles by Rand Corporation and elsewhere, are beginning to provide some interest. And we'll go through some of the data that is behind that.

But if any organization has transformed, it's a fair question to ask what the characteristics of that transformation are, and I think it's instructive to go through those characteristics of transformation, because at each period of our respective existence, I think we need to evaluate where we are and where we're headed.

I think 10 years ago, when VA was not widely regarded as the best care anywhere, there was a burning platform. VA had to transform or it would be rendered obsolete.

The model changed as well. Ten years ago we were a collection of hospitals offering services for patients who somewhat fell through a safety net and had a catastrophic episode that

required us to intervene.

Now it sounds sort of noble to say, safety net. But if you get beyond that image it's somewhat problematic. It suggests that you catch the patient after a problem has occurred.

Wouldn't it be more rational, wouldn't it allow better outcomes for the patient, wouldn't it be more efficient to prevent those problems in the first place? Isn't the model of health promotion and disease prevention inherently more effective, certainly more humane?

Third, we had to build systemness. We were a portfolio of hospitals previously. Then to achieve that aspiration of moving from a system which espouses health promotion and disease prevention we had to have integration of services not just between hospitals, but between all aspects of the continuum of health care.

When we developed networks, it was a vehicle to help create that "systemness". The networks, the 21 businesses that we have today, Veterans Integrated Service Networks, are the fundamental financial funding unit of our system, and the fundamental accountability unit.

And that construction, that construct,

requires that resources and activities be coordinated so that the care of the patient, be it at home, long-term care, or ambulatory care, in the acute care hospital, even care that might be provided outside of VA proper, is coordinated to realize that aspiration of promoting health and preventing disease.

Fourth, performance measurement. Some people have not only said we measure aggressively, but we measure obsessively. And I'll come back to that momentarily.

And fifth, the use of the electronic health records, something that I am personally passionate about, but something that I think our president, our nation, recognizes is one of the most instrumental tools in rationalizing and improving the safety, effectiveness, efficiency, and in fact even compassion of contemporary health care.

Let's take a tour through the history a little bit of VA's experience in the past decade. People always try to project what the future looks like. Here is Star Trek for those of you who followed the original, and I'm always reminded in thinking about the future Yogi Berra's immortal words, forecasting is always dangerous, especially about the future.

And in fact, 2,200 they haven't gone very far, only to have these sort of digital devices in the background of a fairly classic sort of doctor-nurse stereotype that's there.

Well, if we flash back to 1995, the patient who might have come to us, a 65-year-old gentleman with diabetes, high blood pressure and health disease who had a bypass and smokes, and in fact still smokes, and a positive family history of heart disease, on a medication today we know he shouldn't have that doesn't decrease but in fact increases mortality after heart attack.

If we look at the services 10 years ago that he should have had, like a flu vaccine, and not getting it, or a pneumonia vaccination or cancer screens or tobacco screening or counseling. A lot of these things didn't happen.

A lot of these things didn't happen because like most of health care our records were on paper. In fact in VA 10 years ago the rate of having a chart available at the point of clinic visit was 60 percent; 60 percent.

Hospitals as I mentioned operate independently. And if one was worried about things like cancer screening and flu vaccination, control of

hypertension, everyone thought they did well. But absent the data, one really did not know.

As I mentioned we wanted to move from being a safety net to an integrated health system espousing health promotion, disease prevention. And we divided into networks. And the networks as I mentioned were fundamental funding and accountability units.

And we began to implement performance measures. This chart is illegible at any distance, but if you look up close none of the numbers are good. In fact, the rate of simple things like giving a patient a vaccination against flu or pneumonia was 27 or 26 percent respectively for the appropriate patients.

Now the bad news was that there were some problems there. Equally bad news was that while this was not measured systematically across the country, the rates in the country at that time were virtually the same.

Well, a lot has happened over this past decade, a lot in terms of understanding of the challenges of safety and quality and the opportunities for measurement. Certainly one of the things that we're all sensitive to has been the

increases in cost in the past decade. And in this graph we show two things. The green line actually shows the medical consumer price index, and the pink is the Medicare per capita payment increases in nominal dollars over the last 10 years.

The practice of health care has changed. Here on the bottom of the chart it shows that there is a 40 percent increase in the rates of medication prescriptions in individuals over 65 years of age.

And in fact galvanized in the public consciousness is the fact that we recognize that there are big lapses in safety and in quality; absolutely emblazoned on the public consciousness in 1999, the Institute of Medicine Report, to err is human. But as many as 98,000 patients will die every year in hospitals not only because of errors but adverse events that are potentially if not generally preventable.

And the rest of the story, two years later, the Institute of Medicine's subsequent report, Washington Quality Chasm, that virtually every patient experienced a gap, a chasm, between the care that they actually received, and the care that they should have received, on the basis of the best scientific evidence in and around their condition.

Has there been some progress? There has in fact. If you look at rates of immunization, as I mentioned before, flu and pneumonia, where it is measured in individuals over 65 years of age, you see that as a country we are approaching rates in the high 60s and low 70 percents.

I hate to tell you this, but if you look at all Americans who should be immunized, the rates are still approximately 50 percent. And if you look at individuals under 65 with chronic illnesses, the rates still hover in and around 40 percent.

So we've got some opportunity for progress. RAND Corporation, and Beth McGlynn and other investigators actually looked at performance in terms of evidence based indicators of quality and prevention and disease treatment in a number of medical markets, some fairly sophisticated medical markets including Boston, Cleveland, and Seattle.

They looked at overall health indicators – preventive care, acute care, chronic disease. And they found that about 55 percent of the time we got it right.

Carolyn Clancy, the direct of AHRQ, I remember talking to her, she said, I don't know how to inflect my voice on the basis of this data.

Should I be excited that 50 percent of the time we get it right? I'd be absolutely flabbergasted but today 50 percent of the time Americans still get care that is suboptimal.

And if you dive a little deeper into particular areas, from substance abuse, screening, cancer screening, immunization, you look at chronic diseases as well, there is a little more dispersion around the indicators, but the story is still the same. The rates of performance are still averaging in the 50 percent range.

Have we made some progress over the last decade? Well, the answer is, we have, actually. In heart disease there has been significant decrease in early mortality from heart disease, from 321 to 258 early deaths per 100,000 from heart disease.

But some other things have actually come up - diabetes, with the epidemic of overweight and obesity, and Alzheimer's and kidney disease really coming on.

And cancer, I wish we'd made more progress. But in fact the rates have been relatively stable.

Now let's take our story back to VA. Who is VA in 2006? Well, we're a system that's big,

cares for 5.3 million patients. It's a pretty remarkable number, because 10 years ago we took care of 2-1/2 million veterans. And 10 years ago there was no concept of enrollees, and today there are 7.6 million veterans who are enrolled for the opportunity to have care with VA, and in a given year 5.3 million will use VA for care.

We provide care across the country at 1,400 sites. Our budget now is in excess of $30 billion; nearly 200,000 employees. We are affiliated with 107 of the nation's 127 academic health systems, and we have affiliations nationally with 1,500 schools of health professions education.

In addition to the people who work directly for VA, there are many who come to us as parts of these relationships, augmenting our staff of 15,000 physicians are 25,000 additional faculty who come to us through other relationships, and 90,000 trainees, and nearly 150,000 volunteers.

We are a system that does a great deal of research, nearly $1.7 billion of research in the basic clinical, rehabilitative and health services area, all focused on our mission, improving the health and well-being of veterans.

Our population is one that some might

view as challenging. In the insurance parlance it might be viewed as adversely selective. But it is a population that we are truly privileged to provide services to, and we think we are among the best at providing care to those who have a number of characteristics that are likely to increase the complexity of their care.

And I would note that despite the fact that veterans on average do better socioeconomically than the average Americans, the veterans who do use VA for care are generally older, 49 percent over 65; sicker, three additional physical, one additional mental health diagnosis; and less economically well off – 70 percent with incomes less than $26,000 a year use VA, and about 38 percent today with incomes less than $16,000 per year.

Now you may think of VA as typically monolithically male. In fact that is still the majority, but in some of our outpatient clinics veterans under 50 years of age are made up of about 22 percent women. And if you look at the makeup of today's military, women are about 14 percent of today's military.

So what happens to that prototypical veteran who comes to care in VA in 2005 with the same

diabetes, high blood pressure and coronary artery disease? Well, instead of a bypass, at this point perhaps he's had drug eluding stents. He no longer smokes – in fact it's been shown the more often you counsel the better the rates of tobacco cessation. We can pretty well say, even guarantee, that he or she has been counseled virtually 100 percent of the time at least once, and 80 percent of the time at least three times to stop smoking.

In fact we can know that the patient is on the evidence-based care, better than a 99 percent chance that this heart patient is on aspirin; better than a 98 percent chance on beta blocker; similar rates on ACE inhibitors, and 100 percent certainty that his or her electronic health record has allergies documents; 81 percent chance, even in the flu vaccine shortage years of having a flu vaccine national benchmark rate of 94 percent of having a pneumonia vaccine; better than a 74 percent chance that his blood pressure has been controlled to 140 over 70 – over 90 or better. And while that obviously shows room for progress, I'd tell you that's 30 percent higher than patients formerly under the care of physicians across the country.

Similar rates of performance for

diabetes, and heart disease, and oh yes, by the way, the rate of tobacco cessation in today's VA is actually three times faster than tobacco cessation outside of VA.

How do I get there? Why did I mention this aspect of measurement in this important area? Well, it's one of the tools that has fundamentally changed the patient experience, our ability to deliver quality, safety, and efficient and compassionate care over this period of time.

We hold ourselves accountable to the veteran, to the taxpayer, to the Congress, to the Office of Management and Budget, to ourselves, for not only those things that are sort of self-referential like technical quality, but those things that are fundamentally important to the veteran. Is the care accessible? Is it satisfying? Does it restore function? Does it contribute to the health of the community? And yes, is it cost effective?

In fact we operationalize this every year. The contract that comes out of my office is pervasive to the entire system where we measure in each of those baskets to make sure that we're delivering care that meets the characteristics of being high quality, satisfying, accessible, that

restores function, that improves community health and that is cost effective.

How are we doing? Let me give you a quick report card, essentially a synthesis of both some of the professional literature, and even some of the lay literature. When RAND actually repeated the study that I showed you before for America, looking at VA, they found that today's VA outperformed all other sectors of healthcare on 294 comparable evidence-based indicators of quality and disease prevention and disease treatment.

In fact the statements that the authors made was that overall VHA patients received higher care than patients in other settings, period.

Access, 350 percent more points of access since we opened community-based outpatient clinics. Satisfaction – six years running, benchmark, satisfaction in-patient, and out-patient and pharmacy services, and completely externally administered American customer satisfaction index.

Function: more than half the number of amputations looking at age-adjusted disease-adjusted diabetes-related amputation rates. This is from another study in the Annals of Internal Medicine.

Community health: when 60,000 patients

temporarily lost their city in New Orleans, not one – not one – lost their health record.

In cost effectiveness – oh by the way, while all of this occurred in other sectors, and despite the fact that our budget with great support has more than doubled over that period of time, resources per patient have been constant. Measurably better outcomes in quality, satisfaction, access, function, community health with greater efficiency.

It's a story that has brought a great deal of attention, not only domestically but other countries. Canada, last two months I can think of inquiries from Scandanavian countries including Finland and Denmark and Sweden and Norway and Scotland, England, France and the Netherlands, just among the ones that I personally corresponded with in that period of time.

And if measurement has been a bit of the stick, let's face it, measurement sometimes is not fun. One of the most important supports has been the electronic health record, and that our system is 98-1/2 percent paperless is the reason that President Bush came in 2004, late 2004, to announce that 10-year initiative to make electronic health records available to most Americans.

He did that because he along with others were taking note of a transformation that was pretty remarkable that clearly was characterized as not your father's VA.

A show of hands, how many people in here have actually seen VA's electronic health record in person? Okay, it's about I'd say 45 percent, somewhere in there. I'm just going to take a little digression here. One of the reasons I wanted to use my own laptop was just to bring you not PowerPoints, but the real thing. Names have been changed to protect identity of patients, but this is an actual electronic health record that operates in VA. You put a patient name in here. If there are any critical values, or things that need signing, things I should be aware of as a clinician, those would show up down there. All I need to do is just click on that, we get a screen that is available not only in the hospital but in ambulatory care. In fact, I can even dial in from outside of VA and get to this information.

I have information about the demographics of the patient, just with a click, the patient's received care at other Vas, all I need to do is click on remote data, and if data has been

entered from the Department of Defense in their federal health information exchange, then any data in that archive can be accessed as well.

Active medications, clinical reminders that are due, even things like vital signs. And I click on those vital signs, I can actually, and I like to, sit down with the patient and show them, Mr. Smith, here's what's going on with your blood pressure. And oh by the way, here is your weight, up to teachable moments. It works very, very well.

But the ability to have information available not 60 percent of the time but virtually 100 percent of the time, 99.385 to be precise; it's the up time, half a percent scheduled maintenance is truly incredible, the ability to look at a problem list, or medications, or order virtually anything that one would order throughout a health system from labs to imaging studies to look at notes, and any note with a blue icon has images associated with it; to look at records of hospitalization, here a 76 year old gentleman, part of his colon resected for cancer, and diverticulosis, et cetera, who happens to come in today with a gastrointestinal bleeding that would make me want to look at his labs, and particular his hematocrit to know that his blood level was okay.

And the ability to know every blood level he's ever had in his interaction with the Department of Veterans Affairs; to know the values between these two red lines are the normals; or to know that there is a lot of activity here that is probably a hospitalization, and to be able to literally go in and zoom down and know that he bled down and was transfused and bled down and transfused again; or the ability not to spend money and waste time managing films that can only be visualized in one place, but to have all of these images immediately available and online, the ability to look actually not only – and sorry for the after lunch treat – at a bleeding colon, but the ability to actually have images that allow us to make a diagnosis, here a bleeding scan. The ability to look at a study that is angiogrammed, where dye is injected in the blood vessels. And you obviously recognize the aorta, and going down to the legs. And these vessels over here go to the colon, and I might tell you that this one looks like it's bleeding, because it's getting wider, not narrower. And from out there in the audience who might say, well, that looks pretty fanciful, I take your word, but I can't see it, to do things that you can't do with film, like change the contrast, and be able to

see fairly immediately that that vessel indeed does get wider, not narrower. And if it's still difficult to see, I'll just change it, and now you can see, this vessel unlike the others gets wider, not narrower.

The ability to do this, the ability to put a catheter there and block this artery from bleeding, instead of taking this frail patient to surgery, the ability to know this information in the intensive care unit, in the operating room, in the emergency room, even as the patient's primary care provider whether I'm in the ambulatory care clinic or at home is part of today's VA; it's part of the reasons for this transformation.

I'll show you what happens for instance to the patient who comes in with chest pains today who in the past might have repeated studies. In fact, today, what I might do is actually be able to call up at my desk an image like this that actually shows the beating heart when the patient is having chest pain, or the surgeon wants to remove before operating or doing another sort of intervention, can actually look and fairly quickly understand that right there is the blockage, that that is probably where the problem is.

This is today's VA. This is why I personally can't imagine going back to practice with pen and paper, 99.35 percent available.

An environment where an electronic drug order is actually dispensed robotically, and when it's administered, a nurse matches the bar code on the medication with the bar code on the patient's wrist band. An environment in which outpatient prescriptions are electronically transferred to a mail outpatient pharmacy that not only allows us great efficiency and economy in filling more than 230 million 30-day equivalents, but allows us to do so not at the national rate of one in 20 prescriptions being complicated by a drug error, but with performance in those CMOPS (phonetic) that is nearly 6 Sigma. The mythical 6 Sigma is a failure rate of 3.4 per million. These systems operate with a failure today of 7 per million, or 5.85 Sigma.

I'll put that in context momentarily.

So a system that is informed with electronic health information, that can pump that information to provider teams, and even to patients, and improve the interaction, and most importantly, improve the outcomes, and oh by the way, all for about $80 a year, a system that we hope others might

use in rural and underserved areas in particular, and is now available through partnership with Health and Human Services.

Well, if that's the last decade, what about the future? And what about the future that we'd look at as we look to protect relationships that we would think are important, that we hope you would think are important?

Well, what are the challenges in health? Well, even today, and we've known for the past 30 years, that tobacco leads to about two out of every five early deaths and onset of disease and disability.

Also another trend in America that is pretty alarming, actually, the effects of overweight and obesity, poor diet, are going to surpass tobacco as the number one cause of early mortality. In fact our country is a growing country since 1980. And this affects us today, even in today's military about 54 percent are either overweight or obese, overweight being 27 to 30 body masses, and above that being obesity.

I'm not sure that people are truly aware of the magnitude of this epidemic. I just share with you a quick series of slides to ask you whether you

think this has the characteristics of an epidemic. And watch the darker areas as we look at rates of obesity since 1985, 10 to 14 percent in this sort of darker blue on the page right now – 86, 87, 88, 89, 90, 91 – 15 to 19 percent in the dark blue – 92, 93, 94, 95, 96, 97 – over 20 percent in the 10 – 98, 99, 2000 in the red, over 25 percent, hope you enjoyed lunch. 2002, 2003. Okay, I'll show you that again, just so you can see just how incredible this transformation of our country has been that presents a daunting health task for us all.

Obviously in VA we're a little bit ahead of the curve in terms of the ageing of the population in the United States today. We got from about 32 million over age 65 to over 70 million over age 65 by 2030, and the rates of the older old, those individuals over age 85, increasing even more rapidly.

Multiculturalism, not necessarily a problem, in fact an opportunity, but one we need to recognize. Four states already have traditional minority-majority populations, and four states in addition to that have traditional minority populations that are 40 percent of the population.

Where else do we need to change? We

need to change in terms of recognizing threats and challenges to the environment, both manmade and natural. And was this point ever driven home to us this past year with the catastrophe in and around Hurricane Katrina and the follow-ups of Rita and Wilma.

Challenges, there are estimations that we are significantly under producing not only nurses but doctors, and challenges for the way we have always looked at health care is changing right before our eyes, a system that is decentralizing, a system where the hospitals are no longer the focal point but here is decentralized to imaging centers and surgical centers and even Minute Clinics. How many of you have heard of the Minute Clinics? Interesting. They're really making a sweep now in Washington. They started in Target and Cub (phonetic). They're now in CVS, Walgreen's, and other sort of similar venues. They are nurse-practitioner driven, provide service for 31 diagnoses. By protocol, their motto in some places is, 15 minutes or it's free.

We're decentralized not only to information supporting physical sites of care, but actually information as therapy, and whereas the hospital becomes a vestige of its former glory, an

ICU on top of an OR on top of an ER. And with all this decentralization, information becomes even more important. Why? Well, some statistics from the president's information technology advisory committee show that in the United States today, every seventh hospitalization occurs because previous records were not available; every fifth lab test is repeated because previous records are not available. And the great work from Leaf and Bates and others, every 6-1/2th hospitalization is complicated by a drug error; et cetera.

And obviously we discussed some challenges – the safety gap, the quality gap, and I would have to submit a compassion gap in care that is not patient focused.

And clearly all of us share an interest and care or concerns that we have a value gap as well. Some even estimate that 31 percent of this $1.9 trillion dollar health care economy is waste.

What are our challenges in safety and quality? Well, you know, air travel is remarkably safe. Events are far, far rarer than one in a million. Anyone here lose a bag in airline travel? Show of hands, anyone ever had a bag lost? Look around you please? Hands up, pretty awful, huh?

Guess what. That's two orders of magnitude better than our best performance in most of health care. When we get beta blockers right 98, 99 percent of the time, and VA is the benchmark in that, that's two orders of magnitude less reliable than baggage handling.

And today an immunization in the country, again, VA the benchmark, 94 percent national rates, about 55 percent for pneumonia vaccination. That's three orders of magnitude poorer performance, and something we look around and laugh because we take for granted that everyone knows that baggage handling is bad.

We've got some real challenges in our production processes in the ways that we approach health care delivery. And by the way we're spending a heck of a lot of money on this. As I mentioned, up to $1.9 trillion, estimated to go to in excess of $3.6 trillion by 2014, and decline from 15 percent to over 19-1/2 percent in that same period of time, and that has an impact on competitiveness for the entire country.

Here you look at the private funding and public funding of health care as a percent of GDP in the United States, and we can't make up that

competitiveness with better production processes in making cars. We have to make some improvements in the way we deliver health care and improved value.

Well, the road ahead could be a little bumpy, and the good news in the slide, tsunami in Micronesia, is that the train actually made it by. And so I can promise you this, despite the challenges, it is going to be a pretty exciting ride. Because there are some incredible things coming down the pike that we all want to be involved in that will improve care for patients.

What do I mean by improved care? And what are our aspirations in VA for the care of veterans? Our aspiration is that the care veterans get is characterized by the attributes of being safe, effective, efficient and compassionate.

And we come to these attributes not only after formal study of the quality in health care, but personal experiences and family experiences with health care. And what is the litmus test, what is the hallmark of care that actually reaches these attributes? It's that the patient receives this care systematically, and without the need for someone to jump up and down and say this needs to be fixed; without the need for an advocate.

So we've got this backdrop of challenges and safety and quality. What are our goals fundamentally? Why do I come to these four areas – safe, effective, efficient, compassionate health care? How to avoid getting it wrong? It's not adequate just if a surgeon washed her hands. And you can make sure that there is consistent reliability, better than three orders of magnitude less than baggage handling. That is the second attribute.

The efficiency in every health system – need to make sure the resources go further. It's affecting our competitiveness. It's affecting our ability to even meet the needs in terms of delivering health care.

And in terms of compassion, why do I choose the word compassion? I choose it for a couple of reasons, first by saying I'd like compassionate care, it's really hard for anyone to argue against. You're not going to be the person who is going to say, no, don't make it compassionate, make it really something else.

Second, is that this is the term that I think is the place to refer to another term that means to many things to different people, patient centered. I don't think anyone knows today what

patient centered really means. I mean four attributes by compassionate care in VA: care where increasingly the patient and/or caregiver is the locus of control; two, care that integrates across health care environments – outpatient, home, in our context care that may be outside of the VA proper, care within; care that integrates across health and disease so that when I go to the emergency room with a heart attack, there is some understanding of what my risks were beforehand and conditions beforehand; and care that integrates across diseases. You know, it's very compelling today to feel satisfied with disease management, but imagine a patient with diabetes and heart failure, two diseases that frequently occur together. Think of the patient as being disease managed if they're getting conflicted advice, maybe even duplicate prescriptions, and certainly there is an inefficient, a redundancy, at providing care in that manner.

How do we actually provide care that integrates across health and disease, disease and disease? And the final, four characteristic, care that anticipates needs rather than just reacts to them.

And there are some great opportunities

for pediatric – for children with asthma. You can actually predict on the frequency with which they get re-prescriptions of inhalers when a kid is going to end up in an emergency room. You can predict on refills of nitroglycerine when an adult is going to end up in an emergency room with unstable angina or even a heart attack.

And also as we move forward, if you have an electronic health record you can bring together genetic information, and instead of waiting until my cholesterol is high, you can actually predict and treat that too.

So the model for the 21st century, 2006 and beyond, has to extend beyond having a good interaction in the bricks and mortal of a clinic. It's got to support patients and their caregivers in the community as well. It's got to be linked together across all sites with good information. And it's go to support patients even at home everyday at points of service that are not only decentralized from formal health care establishments, but are things that are completely alien to the way we think about healthcare today.

This is my health bed. It's the patient's personal health records, patients who log

on securely into the VA, they can now refill prescriptions, update allergies, they can actually look at their problem list, they can add to the problem list, they can actually go to evidence-based information, and be not only informed but activated and empowered in their own health interest.

So maybe the heart patient isn't told, hey, you have heart failure, you should be on an ACE inhibitor, it improves your function, it improves your likelihood of not being in the hospital, of not even dying. Maybe the patient is the one who comes in and says, I have heart failure, doc, nurse, pharmacist, shouldn't I be on it?

And in fact as we can use additional tools to support and care for patients in the community, increasing their control. This is something that is particularly important to use, the rates of older veterans going up, and the traditional models sometimes necessary for institutional care, but sometimes when a patient has social supports or doesn't have profound disability, not the best approach.

Here is data from Denmark and Sweden showing institutional care for elders in their eighth decade is virtually equivalent per capita to gross

domestic product. So even if it were affordable nationally we've got to think about better ways of delivering care, not just in VA; we're a little bit ahead of the curve, but in our country.

Imagine a patient with heart failure. I used to present this patient in the abstract, but my 88-year-old World War II veteran uncle is this patient. The individual with bad heart failure who is seen in clinic every month just in case.

And if he gets there he's doing well. And two weeks after he gets there, almost invariably, he can end up in the emergency room, fluid overload, difficulty breathing, swelling, maybe even get a breathing tube, go to the intensive care. Imagine if instead he had some awareness daily about that patient, and knew that the weight was going up, the breathing was getting worse, the swelling was increasing, and rather than the catastrophic presentation to the ER, that as this is occurring, the patient gets a call, how are you doing. Having a little difficulty? Why don't you take an extra fluid pill.

And back at the ranch, a care coordinator, aware that 298 patients are doing well but two are having problems, alerts the clinician.

The physician practice team, there is an intervention just in time rather than just in case. Imagine if they were using a low tech high tech device where they could ask those questions while the patient was standing on a digital scale.

You don't have to imagine that in VA. That is part of how we give care in today's VA. And if we enter into any sorts of relationships, this is the kind of care. These are the kinds of approaches that we would want to partner around – care that is good for the 21st century that is really described by the characteristics of being increasingly safe and effective and efficient and compassionate.

There are lots of new technologies to pick up, not just tumors, but also key in to the DNA that is specific to the patient's tumor. Electronic health records in the future are built not by dictating or typing, but as a byproduct of actually examining the patient.

Where the point of service is not the clinic or even the outpatient surgical center, or even the Minute Clinic. But here in Japan, a blood glucose device, blood glucose monitor, glucometer, it's not just cohabitating with a cell phone but actually is one device that shoots those blood sugars

back to the care team and into the patient's personal health records as well. So the point of care for this diabetic patient is anywhere and everywhere the patient goes.

We've got to in short change from an industrial age model where care is in the factory to an information age model where care really revolves around and follows the patient; where the knowledge is in the high priesthood, to an environment where the knowledge is actually pretty ubiquitous; where the real challenge is not getting the knowledge but knowing how to use it, knowing how to use it and apply the evidence and evaluate the information, and remove one system, one size fits all, the Model T Ford, any color as long as its black, as was advertised, to mass customization to where we actually apply the general frame of evidence uniformly, but tailor specifically to the needs and circumstance of the particular patient, in the future based on general information often; evidence-based personalized health care.

The promise of genomic medicine, all the big diseases, all the big challenges, many of the behavioral influences around the rest of genetic components. And from that linkage of genetic

information with clinical information really creates a repository not only for research but for treatment. This is not science fiction; this is something that IBM and Mayo Clinic signed a deal to do, because they wanted to bring state of the art care to their patients.

The Journal of Personalized Medicine sees that cancer therapy is changing now from not only identifying a type of cancer, BRCA Type I genes and this particular breast cancer to the particular DNA sequence in the specific patient's cancer, and tailoring treatment to them.

Even in mental health care, moving to dosing that's adjusted on the basis of the person's particular genes.

It happened in VA because we have this advantage of having this exceptional health record, stable population, a high likelihood of participation by veterans who are exceptionally generous in participating in advancing health care, but also because we and they want them to have the most effective, the most efficient, the safest and most compassionate health care, and allow us to work together to move the clock back from the bypass or even the stents, to not only managing cholesterol,

but preventing the subclinical problems that are occurring as a person's cholesterol is building that are now known to be associated with early onset of dementia and other problems, care that is not just preventive but that's predictive.

So what happens to the patient that the VA cares for in the future? Well, my image of what might happen in 2015 is that same individual with diabetes and heart disease comes in and instead of taking a shot for diabetes he's now on a glucose clamp that measures blood sugar and actually provides insulin, and he has gene therapy. And in 2010 that his blood pressure is not hit or miss in terms of making a decision; in fact there's a profile match to his genes. With coronary artery disease, instead of having a surgery or a procedure, he actually gets a biological, an angiogenesis growth factor that helps to sprout new blood vessels.

And my favorite in here is that the 35-year pack a day smoker actually has a very focal removal of his pleasure center associated with nicotine, a nicoblation, and no longer has a desire for tobacco.

Well, as I said at the beginning, forecasting is always problematic, particularly about

the future. I don't think this is so far fetched. Ten years ago if you actually asked the DAB where it is with the electronic health record be where it is, I think one would have been equally skeptical and fairly so.

But our work is cut out for us, and we share the challenges of the environment, increasing cost of health care, increasing dissatisfaction. And we have some incredible opportunities. You know I look forward to the ability to work with you on this, because we have a shared challenge, which is not just injecting money into a problem, but making sure there is value for money.

This has really been the sort of hallmark economically, financially, of the VA's transformation, so I want to digress to some very specific points on the purpose of this gathering today. And I'm here personally to welcome you, to invite you, and to thank you all for your participation in considering being a part of a chapter of working toward a vision for health care, and an opportunity for veterans that is reflected in some of the ideas that I hope people don't think are too far fetched, that together in our resolve to provide the best care anywhere we actually have

opportunities to really lead and break new ground in not only some of these new technologies, but new acco0untabilities and new approaches and new opportunities.

In our resolve to provide the best care, we've also held ourselves accountable for access. As we've done that, and as we've grown, we've been doing a lot more contracting. Our contracting has been very interesting to observe. Demand for care increased our contracts, part of the way in which we deliver health care. But I need to tell you, something fairly frightening to me, it's actually increased our costs even more.

And I'm here in a sense kind of like GM or Ford or United Airlines saying that if the costs of purchased care continues to escalate disproportionate to the number of patients, it's not just our problem; it's all of our problem.

In point of fact, we're approaching nearly $2 billion of services that we purchased. And this is up 50 percent over the last 4-1/2 years alone. And the number of patients served by that increase in purchased service is up 12 percent.

Okay, now one can say that there have been secular effects in terms of cost inflation and

health care, and I would absolutely agree with you. The only problem is, when we look at our own health care, with measurably better quality, higher access, et cetera, improved satisfaction, we haven't experienced that.

So here is the opportunity, here is the opportunity to partner in terms of really making sure that both of us are prepared for 2015 in a manner that delivers safe, effective, efficient, high value, high performance health care.

I should note to you that operating the way we do today I'd be remiss if I didn't concede that it is our preference where we can to deliver the care within VA proper, and I say this because you've seen, we measure. Not only aggressively, as I mentioned, some think it's absolutely obsessive. But as we measure, we know what the quality is.

When you are health care consumers yourselves go out and receive health care, do you feel comfortable that you have as much information about that health care as you do when y0ou go out to make a purchase of any commodity, be it a car or a toaster? Where are your Consumers Reports? Where is your information about that purchase?

Now I'll concede to you, we have a

challenge that access is a prerequisite for quality. Without access there is no quality. And over the past 10 years the demand has been substantial. We're glad at that, and we want to make sure that any wait times are as short as possible.

We've obviously held ourselves accountable through a great deal of measurement, and we've done that to ensure that we can be effective, and that we know our performance. We want to make sure that as we partner, that we partner with progressive entities that are equally committed to understanding performance.

And work with us to make sure that it's not just measurable performance in isolation, but work with us to make sure that there is a continuity, that if a patient receives care at a VA proper, that the information is equally as seamless in terms of informing his future health needs or her future health needs, as if that patient has received the care inside the VA itself.

So we actually like to work with entities that would like to push forward electronic health records, share information electronically. When you see a veteran, we want you to care to have that same systemness, and be as seamless.

Now obviously, there is no secret, that there has been a lot of discussion in Congress, and we have discussed this issue with Congress a good deal, and they have obviously provided a good deal of guidance for us. And on January 6th, according to the conference report, Congress asked VA to establish a managed care demonstration program, set of programs, that would help establish a process for purchasing care from private sector providers cost effectively, and in a manner that complements the larger VHA system of care, that preserves important agency interests and partnerships.

I think that is really part of the forum here is I wanted to, at least in my comments, introduce you to what we feel absolutely passionately about, and we believe that you feel absolutely passionately about as well, both in terms of advancing health care, and the unique privilege of serving veterans.

I know that some of you may be thinking, when we talk about performance measures and electronic health records, oh great, what a pain in the tail. And I've got to confess that it may be, truthfully, in the short term. But what I'm suggesting also is that we in VA look at this

opportunity in 2006 as we've looked forward in 2005, and we have to ask ourselves, what does the future look like? Are we prepared? Or are we going to be obsolete?

And that is a question that America has to ask itself, and America is asking itself right now, about health care. I put up the title slide, I don't know if any of you caught it, I have The Lexus and the Olive Branch, a parable for health care question.

And with the system, it has some of the challenges we face, with costs that are impinging on competitiveness in our country, with the clear direction that the president has given in terms of the importance of electronic health records, with the tea leaves as I read them, that ultimately providers will in some way be rewarded if they participate or penalized or not rewarded at the same level if they don't participate with electronic health information, it would seem that this is a really exciting opportunity to partner with a system that has made a commitment to something that is clearly a part of the environment not only today but even more in the future.

Performance measurements, associated

accountability and electronic health records and information, and I would hope that you would believe that our partnership and using the tools of the new VA would help you build more durable product, better product, despite some of the challenges that you might see in the shortest term.

I'd simply suggest that new healthcare market rates will require measurement and health records, and requesting again for us all to lead, follow or face even greater challenges.

Our partners need to share that vision for safety, effectiveness, efficiency, compassion, without the need for an advocate, to help us all transcend the limitations of very focused case management and disease management, focus on care management. We care not for diseases, but for human beings, and we need to ensure that in fact that for all of our boards of directors, and for all of our beneficiaries, that we get the most value out of every dollar that is entrusted to us.

With barely disguised irony Robert Frost once wrote, good fences make good neighbors, and that's I'd say not true, especially when it comes to the care of veterans, and especially when it comes to relationships that need to be reciprocally informing.

And I hope that this sets a framework for us to achieve the goals that Congress set out before us, and appreciate and ask for your support in our sacred mission and critical responsibility of caring for veterans.

As we go through this process our obligation is to keep you informed and as knowledgeable as possible about the demonstration project's objectives, and the programs that will help us meet Congress', and more importantly, veterans' expectations.

And I would suggest that the obligation to us is to help us understand how your skills and expertise can help us achieve that goal, and together I think we've learned from each other. I don't think this is a series of individual projects. It's really part of an evolution, and perhaps even a co-evolution, an opportunity for entities which have not been traditionally engaged to engage and partner, not only in the transformation of VA health care, but I fully believe in the transformation of health care more generally.

So I look forward to working with you, working together to ensure that every veteran receives care, again, that has a hallmark of being

described by those attributes of safety, effectiveness, efficiency, and compassion, the sort of care that each and everyone has earned by service to our nation.

And if you partner with us, you need to share the vision, as you will be contributing to what we take as no less than a sacred promise, certainly a noble mission, recorded in Lincoln's immortal words, and the promise of a grateful nation to care for those who have borne the battle.

Thanks very much.

(Applause)

MR. LOPER: Dr. Perlin offered to accept any questions, as far if you have any for him.

Comments, questions?

AUDIENCE MEMBER: That was a very nice presentation. And I was just wondering if we may have a copy of it?

MR. LOPER: Sure, we'll get a copy out, thanks. That was a remarkably easy question.

Okay, well, then thank you very, very much for what you do, and for all who serve American veterans. We appreciate it a great deal. Thanks.

(Applause)

MR. LOPER: I propose that in just a

moment we take about a 10-minute break. But I'd just like to say that in the public press we've seen it reported, uncharacteristically even in refereed journals, particularly in refereed journals, that VHA is noted for having wrought a miracle in its health care performance.

I would just like to say that I think we could commonly recognize Dr. Perlin as a primary architect of that transformation, and an enterprise leader that has enabled that miracle substantially for our veterans and for the American people.

He has clearly offered a fresh and powerful vision for all of us today, and I'm quite excited, as I think when we come back from break and we address some of the content and ingredients of what we are about to do, I feel a heavy responsibility, as we all should, that we can put something up that merits consideration as responsive to the vision that Dr. Perlin has put forth.

He has also narrated a tremendous platform for us, I think issued a passionate call for partners in an unprecedented way in the Department of Veterans Affairs. And I couldn't think of a better charge to the group.

So thank you very much, sir.

(Applause)

Suppose we take a 10-minute break, and come back at about 20 after if you will.

(Whereupon at 2:13 p.m. the above-entitled proceeding went off the record to return on the record at 2:32 p.m.)

MR. LOPER: Okay, ladies and gentlemen, if you would go ahead and take seats, we'll move to the next stage please.

Welcome back. Everybody can hear me? Anybody hit the mike? Anybody hear me better? Can you hear in the back?

Welcome back. I'm still sort of just struck by Dr. Perlin's comments, and what a platform he set for us. It's a little daunting to suddenly try to live up to that, particularly about two-thirds of that I've heard a few times myself, but that toward the end, the challenge with regard to this effort and potential partnerships was pretty stunning.

He actually I think he shared that he had written most of that himself last night, because he wanted to be very careful the nature and content of the message that he shared with this group in this

regard.

It is clearly an effort that is very rapidly attracting attention, interest, and opportunity, and you are very much a part of that at this point and henceforth.

I was remiss earlier on in not introducing the people who are sitting up here with me. And let me just take a moment to do that before we get into the content.

Mr. Dennis Maloney is corporate veterans affairs, and works with us on a daily basis. He's the deputy for VAH contracting.

Next to him, Mr. Leonard Nale, who has been pretty well committed to this particular effort, and to the chief business office more broadly, and orchestrates a broad range of contracts on our behalf, and has just been a real engine behind getting this moving in a contract discipline sense, program management.

And the two of these gentlemen, I think, whether I've mentioned it or not, have linked us up to what we think is a very promising and exciting acquisition strategy that will foster dialogue and collaboration with industry and academia. So while today is going to be pretty heavily possibly a one-

way dynamic, it will change in the very near future into a dialogue.

And lastly but certainly not least in this regard I would introduce Ms. Carol Chipman. Carol comes to us not officially on detail, but she was willing to come from Denver to spend a lot of time with us, and has taken over the mantle of program manager to make sure that we stick to cost schedule and performance design; execute the procurement; relate to those around us; and so forth. It's a huge mantle, and I think she joins me certainly today in all the enthusiasm derived from Dr. Perlin's remarks.

I will tell you whatever credit might be accrued in about two months of work here, to get to what I call the 20 percent design, and particularly in recent weeks has been substantially driven by Carol's organization and skills in leadership, so I appreciate that. And I look forward to working with her as we go forward in this really exciting endeavor.

I'm going to try to get off the stage, having done that. As of actually this morning, the contract HERO coordination demonstration has a new name, and it will be known henceforth as Project

HERO, HERO referring to Healthcare Effectiveness through Resource Optimization. I think you heard a lot from Dr. Perlin about excellence and effectiveness, and certainly about resources, the need for effectiveness and efficiency.

He said so many of those things so well. I wouldn't try particularly to amplify those.

But this is veterans health care care management demonstration program. When I mentioned care management this morning, he said those were exactly the words. This is not case management; this is not disease management; this is no particular individual component strategy, but in fact is a broad comprehensive omnibus strategy to provide better managed care for veterans who rely on us throughout the system.

The contract care coordination language actually was that that was the reference in the law, and so we to this point had used that language in light of that. But in the VHA parlance, per se, many of you know, peer coordination means something very different. It's a specific program, and certainly for internal purposes we wish to deconflict those references.

So project HERO, there are actually four

stars between the word project, and HERO, and those alluded to the four missions of the department of veterans affairs, in fact on VHA. Medical care, education, medical research, and if you will, medical preparedness for disasters and national response.

So we commit through Project HERO to an effort so well framed by Dr. Perlin here this afternoon to pursue excellence for veterans and value for America.

That is a daunting challenge, but I think it's an appropriate one, given the charge that Dr. Perlin has shared with us.

Again, Dr. Perlin highlighted the features of this tremendous system, and I see so many friends in the audience. It's a treat to be here and have an opportunity to talk to you.

Many of you may know, I've only been with parts of veterans affairs since last April, so in less than a year to come across an opportunity to do something like this is fairly stunning to me.

And it is frankly an honor to have this particular mission, that is, to serve veterans. I did about 30 years in the Department of Defense, so veterans are pretty close to me.

My dad and I have about 70 years total

service combined. We are part of this community, and it is very important.

We are commonly recognized I think as the nations' largest integrated health care delivery system. And that brings challenge and opportunity.

We have VA medical facilities in every state, and in virtually every territory.

I've enumerated the four missions, and you've seen some of the data. We've got 157 hospitals, and we have this sort of euphemism as far as I'm concerned in VA when we talk about hospitals. But in many, many cases, those are indeed medical centers, huge campuses, complexes, comprehensive services. The term, hospital, almost understates, or undervalues I think the scope and impact of some of these operations.

And then hundreds of outpatient clinics and CBOCs doing all the work that you've seen and heard Dr. Perlin describe.

You also saw this, and this will become significant in the issuance or the partnerships that will proceed forward. In essence what appears to be emerging in response to the language that we will spend a few moments on here shortly is basically individual networks arising to become demonstration

sites.

So that is, we expect a set of entire networks to be individual demonstrate sites in the spring. So it is not two hospitals in the south of something; it is a fairly substantial scope. And I'm not free at this point, because it's not been taken to Secretary Nicholson yet, to identify what those specific sites are, but that will be made very clear soon, and I expect it to be released, I think it would be fair to say, in as soon as that is known. But it will be substantial.

The public law itself, we're pleased to see that Congress expressed its interest in supporting departmental action, or expeditious action by the department to employ care strategy including the public and private sector, and certainly we sort of reserve the prerogatives to identify those we believe are proven, and stand ready to dialogue with regard to those, and we'll have a little more to say about that.

Focus on cost-effective purchasing of care. And you heard Dr. Perlin mention, in a manner that complements the larger VHA system, and in a manner that preserves important agency interests, that the agency again will work to enumerate in

specific terms.

But warranting specific mention in the law are our associations with our medical school affiliates; as Dr. Perlin mentioned 107 of those.

The presumption and the understanding with regard to focusing on purchased care, however, does not simply mean buying care. It actually means optimizing the total system so that we buy care when necessary, and when we buy it well.

We'll have a little bit more on that as well. We are directed to achieve a competitive award for threes demonstrations by the end of this calendar year. That is pretty impression, I would submit, particularly from – within a framework that Dr. Perlin set, I think this is an unprecedented scope and scale of partnership with industry and academia, and to do that and to get an award within a span of 12 months, or 13 months I guess we should say, is challenging.

Also, we are to provide at least three objectives-oriented demonstrations, and by all appearances we will fulfill that; numerically, we may exceed that. And collaboration, with industry and academia, is encouraged. And I guess at this point I would say, that was one of the drivers, frankly, for

this particular setting.

We had begun a course of market research, had some other sessions, and I had assured others that we would go more broadly, and include broader segments of the industry as we clearly wished to do; and this is part of the effort to do that.

Secretary Nicholson is to submit his objectives to the two appropriations committees by the 28th of February. That is the other, or the related reason, that we wanted to have an industry day as soon as possible before that date. And I would suggest or submit that one of the outcomes we would wish for is input from industry and academia regarding formation, scope, intent, nature of the objectives of this demonstration.

And we do have a draft that we'll be sharing with you in this presentation.

The program has to be established in at least three visits. That should be easy to do, frankly. The effort is expected to be comprehensive in scope, and serve a substantial patient population. I would submit that subject to specific design, a demonstration site comprised of an entire network would satisfy our parlance a substantial patient population.

The comprehensiveness, I think we will also be able to satisfy. That is a little bit in the eye of the beholder, but it clearly – Dr. Perlin talked about a partnership to add value to an enterprise like he described it must be comprehensive in nature, and we intend it to be so.

We are free to incorporate a variety of forms of public and private participation, and that is a tremendous framework for us, because it provides platforms for innovations, for creative contribution, for – I began to think just the other day about commercial off-the-shelf solutions, and that is normally in the parlance considered a very positive thing to get to include commercial off-the-shelf applications.

I had a discussion with the assistant secretary of the department about that particular thing, and I offered that I thought that commercial off-the-shelf solutions are often very valuable, but generally they are not generally designed to be fit for use in every context.

Therefore, there is some level of scrutiny that goes into what is an appropriate commercial off-the-shelf solution for us, and what level of adaptation is required.

And he would say, well, but they're 80 percent there. And I said, okay, I'll give you that, and now we're talking about the 20 percent nonsuitability. How much of that 20 percent is necessary difference, and how much is not necessary difference?

My job is to reduce the needless difference, and then to honor the essential difference.

So we would look for commercial off-the-shelf products, but we'd also look – and I think Dr. Perlin sort of laid a wonderful thought down on this – don't just take something off the shelf and lay it over on the VA. There may in fact be some new intellectual work that is required, so it's not off the shelf. It's out of the minds of creative people who have engaged in this.

Multiple awards for designs can be employed, so just another feature of adaptability, flexibility, and latitude.

We're beginning to characterize this very clearly as an opportunity. I believe it is an opportunity, and I also believe it's a privilege. For VHA it's an opportunity to leverage our position, position, scale, special competencies – and we have

many; you heard Dr. Perlin make reference to those – to mobilize taxpayer investments to revolutionize care for veterans.

There are tremendous out there, we have tremendous ideas in here. There is this marriage that needs to take place between partners in this enterprise to improve the care we provide to veterans.

I believe we're going to achieve a national benchmark most effective system, and the system having wrought a miracle is a long way in that direction. But Dr. Perlin would challenge us all to do more, and also challenge us in the tremendous aspect he mentioned, in the business side of it. We saw some tremendous products and advancements in technology on the clinical side. We have some work to do on the business side.

We have an opportunity then to move to the next stage of transformation, and this is it. We have the opportunity for an unprecedented powerful marriage between technology and operations. We saw manifest some incredible technologies that have been proliferated across our system. But there is more work to do.

To secure the most fully enabled,

unburdened practice of medicine, and I think I particularly mean that as the chief business officer, from the business side, to unload clinical providers across the enterprise with things they have to do on behalf of revenue and administration and documentation.

And so there are opportunities here, and we look for your best methods of creativity. We clearly live in a very unusually data rich enterprise, poised to advance quality and safety, advance data mining, pattern recognition, we think there are all kinds of things possible to get at medical intelligence embedded in the data we have.

For business partners, it appears to be an opportunity to advance intellectual capital. I think Dr. Perlin actually made reference to something like that, and he's not seen this before. True VHA open systems. The potential for derived market power comes from being a partner with the largest enterprise in America. It's a part to be part of something grand. They keep painting that picture very well, fundamentally transform it – we're going at this like – this is like generation 1.0 for VHA. This is an opportunity to lay in something that makes sense.

It's a privilege to serve our nation's heroes. It's a position to gain cultural power for your enterprise and ours.

It is indeed a privilege. I think we've painted that picture very well.

Health care operations are strong and best care anywhere. They are operational care measures and business models that could stand some refinement, but technically provider and patient were incredibly strong.

We need to optimize business operations in line with a coherent partnering business strategy to achieve the most effective system. And in fact HERO, Health Care Excellence for Resource Optimization.

Some of the perspectives that I would offer with regard to this effort, I believe, and others join me in thinking that this demonstration opportunity, which is novel, new and prototypical, provides a platform for testing and evaluating the application of promising care management and business strategies for the VHA context. So that is, take your investment, take your products, move them forward, let's try them here where it makes sense and adds value to the care we provide the veterans.

Designs must be supported and will be supported with broader departmental strategies with VHA strategic plan. And those are moving together. Obviously we've had this in had for about two months, continuing playing with as things go on all around us. Active collaboration will be pursued as encouraged in law, and early ambitious in that regard, and we hope within a 12-month period to be able to execute that.

And our strategic partners will be acquired through a competitive award of best value, performance based contracts, focused on statements of objectives, not statements of worth. So we would wish to retain the greatest degree of latitude for intellectual property introduction and creative solution in response to roughly general statements of performance or objectives.

Here are is existing set of demonstration objectives as it stands today, subject to some minor I think expressions or revisions that were offered this morning by our steering committee. I don't think we've made those here.

First, increase the efficiency of VHA processes associated with purchasing care from commercial and other sources. This is I guess

probably the best place to introduce the idea that this is not an outsourcing effort. If anything, at least the first and second objectives would I hope strongly convey that this is if anything an insourcing effort. That is you saw the excellence portrayed by Dr. Perlin, and the confidence that he holds in the care we provide, and we're looking for partners in that effort, not to outsource care, but to partner in better business decisions, better care management processes, and so forth.

So as a result, our anticipation is that if we're successful the proportion of total care provided under the auspices of VHA by the providers should go up over time, not down. We'll see how that bears out.

We also seek to reduce the rate of cost growth associated with purchased care, and that is both a volume and a price feature at least, as well as just intelligent purchasing strategies, and appropriate case mix management I guess.

Thirdly, implement management systems and quality processes that foster efficient safety. And it's very important, and I think Dr. Perlin laid this out, make contractor providers virtually high quality extensions of the VHA. This is probably one

of the most technically risky but high payoff elements of the demonstration, which his, how do we establish that virtual relationship with community providers such that our providers have access to care data, finding secure treatment plans, recommendations of providers in the community.

Also we seek to control administrative costs, frankly, to seek to control those typically associated with ventures like this. And subsequently, to limit administrative cost growth to a rate lower than that experienced in cost of care.

I sort of hasten to say that at least say I'd venture that with the rate of cost growth typically experienced in health care, this should be an easy bar to make. So we will probably seek to quantify that a little bit more to make that a little tougher goal in terms of administrative costs and achievements.

Also where we choose to take this piece of work on, to increase net collections of medical care revenue. And finally increased enrollee satisfaction with VHA services.

We are in the midst – now obviously with the secretary owing this to Congress by the end of the month, we're in the process of vetting these

expressions as well as our data capabilities to even measure those – what are our strategies to measure obsessive benchmark against what our performance standards. And all of that is sort of under rapid exploration, so we can at least tell Secretary Nicholson this is a valid and useful proposed set of objectives.

Some additional secondary gains that we imagine coming from strategic partnerships in the context of the demonstrations, to build upon VHA leadership in providing top quality care – you've heard that well enumerated; favorably influence the positive care delivery in general for VHA; to improve access to health services – so without access there is no quality, that is quite a statement; particularly access to VHA facilities.

We seek to leverage VHA leadership and peer coordination with other innovative peer strategies. We have a number of areas where, we would submit, we're best of class, and we would seek to export those to community providers, as well as import best practices for others.

So this is in fact part of improving the interface to participating providers and business partners, in other words, interoperability. We

intend to advance through the process, to sort of a special interest in facilitating care recovery and hurricane impact, the infrastructure obviously in the Gulf Coast devastated. You heard the comment about how many people were displaced but the records weren't lost. The buildings were gone, many of the doctors are gone, and there are a lot of big problems down there. If we can spin something off quickly for that, that would be very positive.

In general I was so pleased to hear Dr. Perlin talk on the mantle of, we can advance health care in America. And you know if not us, who? This tremendous system called the VHA is in every state. It has robust research, $2 billion of research and 107 medical schools directly affiliated with our operation; and a motive of service and quality care. If we don't do it, I'm not sure who is going to do it. I think we're the best ones. So it's quite a challenge to take on in this context, but you can see the motive as well.

Here are the envisioned I guess 10 to 20 percent design components of the anticipated demonstration. First, these were my short titles called VHA optimization, community optimization, health service integration, revenue support

highlighted in yellow. Those are the four pieces around which the demonstration would behave, and we'd seek to improve something in those four areas.

And the last one is a related effort I'll describe a little bit more.

VHA optimization, the objective as it's currently configured, understood, is to assist VHA with enhancing internal care capacities and processes to minimize the need for purchased care. Dr. Perlin frankly introduced a conundrum that some might anticipate. If it's not an outsourcing issue, then what we really want you to do is help us provide more of the care. And where is the revenue for a partner in this? And where is the interest going to come from?

I think the interest in this is substantial clear, visionary challenging material, intellectual property, and some of the things I've already alluded to, as well as how this rolls out in terms of specific tasks and scope of work I think will also provide some attraction.

But it is basically about insourcing, particularly in the high veteran relevant and specialized components of care for veterans.

Community optimization to develop and

manage care capacity beyond the VHA, so outside our walls if you will. All care capacity extents that we would seek to use in caring for veterans, we would seek that to be optimized, developed and managed. And we recognize that that is all over the map. We are all over the map, so it necessarily is so.

Health service integration, sort of an interesting one to me. I've been identifying and pursuing high value care arrangements for targeted classes of patients and conditions. And this in essence looks for where conditions or classes of patients can have their needs better met in focused ways inside and outside the VHA, and someone who would come in data mining pattern recognition, specialized disease management, et cetera, say, okay these 25,000 patients in this community, or these 12,000 patients in this condition, with this class of veterans, with these special needs, we believe we can do a better job, or we can offer a business case that says we can do that better, get better quality outcomes and lower costs, satisfy the veterans, and do that in your buildings, or both our buildings, or we'll do it for you. And we're willing to go to risk for some or all of that, quite a creative sort of laboratory venture here that is possible under health

services integration.

And we will address each of these slightly in a little more detail, by the way. So we'll see these issues again.

Revenue support, to assist VHA in refining revenue cycle performance, and maximizing that revenue. And we have quite an industry in VHA already with business partners across the enterprise in our accounts receivables management, in our billing and coding and so forth. So in certain instances we imagine this may be included where data suggests; in others it won't, and only the first three components may in fact be extended to that site.

Lastly program evaluation, there is an expectation by Congress and others that we will engage an external entity to conduct the performance evaluation as a result of this effort. So we're in actually across all these now, we're beginning to develop for each of these. So I expressed these this morning as sort of baskets if you will, baskets of work, baskets of capability that we require, and how they relate to each other is a matter, and each of these will be developed and integrated in the next very few months.

So to perform an independent external evaluation, with demonstration results.

Now if we could just take a quick walk through each of these. Again, restating the objective, I'd say I had these in expressions of areas of interest, and in almost the closing moments changed these if you will to rhetorical questions. Because what I did not want to put out was, well, how would you build this? Or what would you give us about these? Because that has a tendency to change the aperture, to limit the aperture of the things that might be contemplated, and I wish to leave it much more open than that, the collaboration involved.

So these thoughts are the kinds of questions and possibilities that come up in association with each of these matters. And in some areas VHA has done some internal work in regards to these, and in others, not so much.

How is medical management evolving? I can remember when we did preauthorization for normal pregnancies; that was kind of ridiculous. Well, we've come a long way since some of those things. In more sophisticated ways, how is this working?

And I guess I'd like to introduce the concept here of leapfrogging. It's a little like

maybe dusting off somebody off the shelf may not be adequate, it may not be sufficiently invented, and it may not be context relevant.

Also, there may be some steps where we can leapfrog the specific solution. So this really could be a creative enterprise.

Sort of comes to mind, it's an example that's been shared with me, and I guess it's in Bosnia Herzegovina, that they were devastated after the civil war, what have you. How are they going to reconstitute person-to-person communications? Where are they going to put the lines in, the telephone poles, and all that sort of thing.

They just put up some towers for cellphones, and they skipped a whole generation, basically, establishing different capability. I'd submit that there are opportunities in this business to skip whole generations, and go right to some meaningful solutions.

What methods best ensure most effective insourcing and provision of care? What would you offer to VHA that would enable us to do a better job in that? What clinical care strategies can you offer to the VHA content?

What lessons has industry learned about

operational efficiency across a range of settings, and particularly from people with conditions such as those we serve? How can staffing be secured and optimized across our scope of work as VHA affiliates and community partners?

What flexibilities and incentives can we put to work to make that happen for veteran care?

What processes most effectively support the compelling presumptions, end quotes, that VHA is the provider of choice to America's veterans? External providers are effective and complementary partners in care.

What incentives best enable or encourage that pattern?

I think it would probably be fair in a morning discussion with Dr. Perlin a couple of weeks ago, someone brought up the discussion of make-buy analysis. We got into this make buy. We're going to make buy. He said, I don't accept make-buy as a useful construct risk. Because it tends in that phrase to treat those two options as co-equal. They are not co-equal in our business. It's not simply are we going to make that or are we going to buy it. He would view it as important, a compelling presumption, we are going to provide it except in the

exceptional instances where the capacity is not there, we can't do it, we shouldn't do it, it's done better somewhere else, there is a powerful business case, but therefore the presumption that we'll provide it, except. And it is the exception that clearly has to be managed.

A few more. How would you foster electronic data exchange that affect interoperability as community providers, that serves continuity of care for care provided in our system. Not just, we know what you did. It's come in in a way that enables our own providers to provide continuous and effective care. How would you propose to do that?

How do we leverage core competencies in VA offices, in care components most essential particularly to the service we provide for veterans?

How do we maximize intra-VHA institutional and business, provided business relationships? Certainly inside our enterprise I think it's safe to report that we struggle with the concept of transfer payments.

There is a medical center down the street that says, we'd like to provide certain kinds of surgeries, and if we do that, and you send us your patients, we'll do that for X dollars per case.

Well, that eventually gets proliferated until you have these pockets of specialization in this building bu9t not that building, and the long term effect of that may set in motion something that is not desirable, so that we can tend towards nonuniform benefits.

On the other hand, maybe there are certain applications for transfer payments, and a basis for doing that. It's just that we need intra-VHA institutional provider relationship strategies to make that work, and make community be part of those.

And then how do we support centers of excellence in that same regard, if you don't allow migration of work to a different center where you specialize? Can you really have the fragments under a relationship? So there are a lot of pieces.

The second big piece of work, community optimization, develop and manage core capacity down at VHA. One of the most effective strategies to secure an effective MIPS (phonetic) of community based providers – care for veterans, purchase of care components – and there are clearly, intellectually we recognize, there are tradeoffs here. You could come in with a 20,000 provider network, because specific spoke and service, and we'd certainly have the

coverage. But how then could you reasonably establish good data interchange, virtual relationships with 20,000 providers, 12,000 of which you don't need because they are OBGYN pediatrics, and what have you. They may not be the right mix. And then there are network rich and network poor environments, or rural and urban. So what would be the proposed strategy, or blended strategies, to get us community care capacity? And how do we ensure quality patient safety and best control costs in that framework?

How do you propose to arrange purchase care services in a style satisfying to veterans? And importantly, how would you make provision for established care relationships that are valued by veterans today. I have a longstanding relationship with a provider who has helped me with my limb loss and my prostheses, and now you're telling me I can't go to that provider any more because you have set up a new system. Well, that would not be well received or well tolerated, and that transition needs to be carefully managed, or special provisions need to be made in circumstances like that.

How would you advance the idea of community providers as high quality virtual extension – we talked about that. What are the most important

features of that interoperability? How would you then relate whatever we do to that system that Dr. Perlin just described? How do you add value to a system like this?

What steps do you propose to still take access? And we heard mention access and services that foster veteran satisfaction with care. Clearly one of the objectives that need to be independently corroborated is at the end of this thing, whatever the end of it might be – another question – veterans are more pleased afterwards than they were before. That hopefully is one of the bottomlines for the whole thing.

Further community optimization, how would you design and operate financial components for timely and economical payments to participating providers? Is that a conventional approach? Or is that novel approach? What are the features of that? How would you minimize out of pocket expenses for veterans?

Let's see. How would you facilitate arrangements between VHA and providers?

Health service integration: how would you identify and address high value care duties and opportunities among veteran populations? What would

you look for? What would you target? Where could you add value? What could industry bring to bear, or academic concepts, be brought to bear on this? What vehicles, care strategies, and financial models would you propose?

So you improve service to veterans with special needs, and advance VHA service sections in general.

Would you propose to go to risk for any segments of this? And how would you ensure the specialized care models and the disaggregation of the care value chain in the grapevine for your care?

Frankly, when I first introduced this concept – it's been through a couple of generations in about a month and a half already, and it's arrived at this one. And it talks about targeting classes of patients and conditions.

Dr. Perlin narrated this pretty nicely this afternoon. He said those specialized applications have a tendency to interrupt continuity of care, across the spectrum of care. He said you can't permit that. We need a better solution that that.

I met with some senior consultants who have said, while there has indeed been specialization

in the industry, part of that specialization consists in developing compensating mechanisms that restore and sustain continuity of care.

So if you get a best in class specialty provider, you can also be plugged in and assure that that is not a stand alone piece of care, and I think you can satisfy that requirement.

In revenue support, if awarded this work, how would you propose to help us improve our documentation and business processes? A lot of this work is going on already. This could probably be a harmonization in the demonstration site, where it appears appropriate.

What special qualifications, effective strategies, or innovative models would you or your partners or your teams offer? And what components of risk would you be willing to accept in this regard? Frankly, we've had fairly conventional experience with risk on certainly the accounts receivable. It's not due in this department. But those are features of this.

Those actually are the components of working. This almost understates it after Dr. Perlin's talk. But we look forward to the unique opportunity that this provides, the enhanced service

to veterans. We can make the VHA even more effective. We can move forward in the transformation for VHA and for America, we look forward to structured engagements with industry and collaboration with thought leaders. We will actively pursue and engage thought leaders across the industry during this entire period, to the extent permitted by contracts, to solicit ideas, to get at the intellectual capital.

And I would submit we have an outstanding mission. We have a tremendous value proposition. We have a grand service motive, and that is in no way mitigated by this undertaking; it is enhanced by this undertaking.

And we seek partners, as Dr. Perlin said, that have an enthusiasm for excellence, for performance excellence, for service to our nation's heroes, and for developing value for America.

We put forth sort of the premise that, once again, we have the potential here to greatly advance care providers, care in our system, and the care models of America. And we've been given an opportunity Congress to have a platform to mobilize intellectual capital and create the test, exercise and evaluate range of options so that at the end of

the day we have a powerful system that operates well.

So excellence for veterans, value for Americans. This I would say defines the 20 percent solutions we have. Obviously with Carol's leadership, the entire growing – substantially growing team engaged in this effort in a very rapid way to get this well specified.

I think I'd say, as I introduce Len I think will be next, to talk about the contracting features anticipated for this, I think I drew almost as much excitement from the contracting model that is being brought to this by acquisition solutions program as I do about the content potential at hand.

It, like the law, will encourage collaboration, creativity, intellectual best practices, and commercial contributions that make a VHA veteran. So this should be an active and exciting dialogue, partnerships, and so forth.

So could I answer or address any questions, particularly I guess with regard to content. Since we're going to try to focus this on process, contracting process, and objectives.

But I think we can try to handle some questions now.

Okay, I thought that might also be the

case. So we look forward then to further dialogue to be sure.

Let me introduce then Mr. Leonard Nale, the chief business office contracting officer.

(Applause)

MR. NALE: Good afternoon. I'm Len Nale, I'm heading up the acquisition team. I'd like to introduce you to the acquisition team, stand up, sit down, next slide.

Okay, most important thing here, we've adopted a proven methodology for conducting this acquisition. It's been proven in the past. Acquisition Solutions came up with it, so I'm not trying to claim authorship of this. But right now, where we're at, we've already established the integration solutions team. That consists of Mr. Loper, our program management officer that Carol is heading up; and our support team to run this.

But now we're getting to the interesting part. Where do you come in? Where do you come into play? Why are you here? Bottomline, you're interested, you're here, because you want to become partners with VA, and I'm going to show you how to do that.

I've got a lot of good slides here, but

Mr. Loper and Dr. Perlin said most of the things I had to say on mine, so I'm just going to get straight to the point.

Right now we are defining some needs and we're conducting the marketing research. You are part of that marketing research.

How many of you have ever heard that a contractor can't help the government write a statement of work? Come on, somebody got to stick up their hand? Anyhow, that's why we're not going to write a statement of work. And guess what? You are allowed to work with us. We are writing a statement of objectives.

Now, what better way to win a contract than to see some of your own words in the statement of objectives that you are going to bid on? You can. I'm going to show you how to do it here.

We are forming teams to come up with the three sites, the three demonstration sites. We're still in the process of step two of defining those needs. We need contractor support to help define those needs. You've heard Mr. Loper talk about the requirements, in our top level major components. Those components are going to be the structure of that need.

What we're asking is that if you have white papers on the subject, corporate capabilities on the subject, anything that you have to contribute to this body of knowledge in the subject areas, send it to us. We'll make sure that it gets to the right team. We'll set it up so that you can work with those teams, talk to the teams.

I've heard so many people out in the hallway say, oh, we can do it better than VA. Well, guess what, this is your opportunity to be able to say and contribute to, show us where you can.

And I apologize that I haven't had a chance to brief my slides, and I may get tired after this, but I'm going to keep moving here. They've already seen this stuff.

The only three things that they told me when we started this acquisition was, it has to be done by the end of the year. We've got one year to put it in place; we're already at the end of the first month. It has to be performance based. And we have to end up with strategic partners.

And it has to be functional, and – I'm sorry, and it has to employ care strategies proven in public and private sectors.

That's what we're hoping to get out of

you from industry coming to visit us today.

What our next step is in the acquisition project, once we get everybody's inputs, have a chance to collaborate with industries, we'll be assembling a statement of objectives. We'll be going out on the street for a request for solutions.

Now that request for solutions, let's skip forward a couple of slides, okay, keep going forward, and one more, what we're looking at, and we're structuring the contract to support how we're going to do the demonstrations. It's not set 100 percent, but this is some of our concepts.

There will be a full and open competition. We'd like to be a base-year-plus options, but that's not set.

One of the things that is set, there will be multiple tasking, and there will be a performance based statement of objectives, request for solicitations. And it will be the best solutions by your words.

Next slide. The valuations will be based upon the best solutions and values. Advisory bodies will not be part of the source selection team.

We have a separate steering committee that is there to give us guidance. They are not on

the source selection board. Individual tasks may be awarded at the time of contract awards.

What is going to happen, we're going to send out the requests for solutions. If we like the solutions, we have the option at that point to be able to award out the solutions to start the task going.

If the solutions come in, the team says, we may want to tweak something here, we are given the opportunity to go back out to the market, to work with the market to redefine those tasks in an opportunity to rebid those tasks and work with them on the solutions.

And we are setting up the contract so that future tasks may be completed among the awardees. What our goal is, after we're finished with this competition, is to identify the business partners that we are going to be doing business with in the future. And with those business partners we're going to be structuring these demonstrations. We're going to be structuring the future demonstrations. And once this becomes assessed, as I'm sure it will, we'll have a contract in place to move forward into the future with VA and the other business.

So the objective now is to be able to be successful in these predemonstrations, get your participation to structure these three visions with your inputs; and be able to have a contact in place that will support the future requirements.

Contract administration: the contract management will be based on delivering results through partnership. You will be our partners in that.

Contract designed to support solutions beyond the demonstration phase. We're automatically assuming with good reason that we think this is going to be a success. We are going to structure this contract that if we're successful in the demonstration we can use it in the future.

Industry and academic collaboration supporting the development of the task. We've already talked about that.

And reformist measures to be used to moderate contracts. We are not the experts in this area, so we expect some good advice on how you would set up your performance measures. We brought some experts on board to help the team structure those performance measures, but we're really looking for some input from industry to give us some input of how

we can structure those performance measures. If you were given a task of how to do it, how would you do it? And how would you do measurement? And how would you like to be paid against that?

And we're also looking at annual refreshments. Just because you may not be included in the initial team, we're looking at refreshing the contract to bring new contractors on board as new requirements come up; and on the same terms, have options that are awarded purely based on performance. If the team likes the way that you're doing business on the demonstration, we're setting it up where they have the option just to give awards straight to continue that and other visions.

These are all things under performance based that we're considering in the development of this contract. But right now, you can be part of that, and what we're asking is that you be part of that.

And I apologize for not going through my complete presentation, but I think it would have put you to sleep by now. So I've been already successful in putting half of you to sleep.

Are there any questions at this point regarding the process?

And could you identify yourself so we know who's talking?

MR. HUELSKAMP: Sure, Paul Huelskamp with NRC and Picker.

In your procurement process are you going to be able to kind of mix and match teams that you see? So if you see a component from one that you would see that you would want to mix and match it with another part of the bid, could you put those teams together? Is that part of your strategy?

MR. NALE: That's what our goal is. And actually that's what Mr. Loper gave our initial instructions on of how to structure this. He wanted total flexibility that if something everybody liked out here, and something they liked here, the flexibility to come up with a total solution. So the answer is yes.

Any other questions? Somebody's got to ask a question.

MR. BACON: I'm Kevin Bacon. Are you going to have services able to set aside piece of this, or component of this? Are you going to have a services able contract quota on this or set asides for this, for some of this? I know it's full and open, but are you looking for numbers there?

MR. NALE: Our goal is to always have service disabled veteran contracts. Actually how this is going to come about, yes, we are encouraging service disabled veteran contracts to bid on this. And we may do due diligence to see that somehow they fit. Being a service disabled vet myself, I have a vested interested in making that happen.

That's not the say that's the way we're going to go, but I have a personal vested interest, and if you look around the room you will see a lot of service-disabled vet contractors that we currently deal with.

So the answer is, I can't guarantee that, but I'd like to see it.

MR. NEGRON: Jose Negron of SRS Technologies.

Can you explain to me, or maybe I missed it during the brief, the timeframe that we're talking about? Is it pretty rapid? Because what you are trying to do is set up some type of proposal or some type of group interaction with various companies to provide services to VHA?

MR. NALE: Sure. I can talk about the high level timeframes. By definition it's been dictated as what our end date is, and that is

December 31st. That is when we're going to have the contract awarded.

And we will –

MR. NEGRON: So do you expect us to be working with you with some of the shortfalls that you may identify through the requirements so that we can have an SOJ by the 31st, so that you can issue a contract?

MR. NALE: The answer is yes, and if we look at the process, if you back up how long it takes us to go through a source selection, through due diligence and – so essentially we're looking through mid-year of being able to get the solicitation on the street, to be able to make a rain date. So from now until about mid-year we're expecting active participation from the contractors to work with the group.

And a little bit of formality here. Some of the things that we're going to do is publish everything that we can on the FedBizOpps website to make it available for contractors.

For example, copies of this presentation we will be putting up there. Any major decision to come out of the steering committee that affects how we're doing things we're putting up there.

We will also put key points of contacts out there to the perspective contractors who they can talk to, because we're interested in getting a collaboration off and moving.

MR. NEGRON: So if I can recap what you just told me is that we are going to interact with VHA, you are going to have a solicitation out by midsummer, and by late December you will have an official contract out to folks, and the contract will vary with one year with options I guess.

MR. NALE: We will have the contract done by the end of December, yes. The timeframe we're still working out the exact timeframe of when that is going to get done. But we can narrow it down within a pretty closed set. About midsummer we'll have an acquisition out on the streets.

Now you are also given a second opportunity, once we put the solicitation out on the street, we're going to put it out there to get comments back from industry under due diligence, make sure, did we capture what it is that you want done.

Give you a second opportunity to come in and say, hey, guys, you missed the mark. This isn't what you wanted. Make sure that what you are going to be proposing as a solution is really what we're

looking for.

And as much as you can help us structure this, we'd really appreciate it.

MR. SCHOSSLER: Hi, Len Schossler with Navigant Consulting. I've got a broad sort of program conceptual question in two parts.

One, would you be taking more of a VISN approach to a demo versus a smaller geographic area?

And two, would they more likely be in the Sunbelt or the Rust Belt? I could see arguments either way in terms of capacities and access.

MR. NALE: I think the short answer is, it's a VISN-level approach with latitude within the VISNs to focus components of work based on demographics and conditions and so forth.

And right now we have – how shall I say this? – candidates from both belts. So I don't think there will be an exclusive belt to reference.

MR. SCHOSSLER: But where do you have the most candidates?

MR. NALE: We'll announce that here pretty soon. It's pretty much all over.

MR. SCHOSSLER: Thank you.

MR. NALE: Okay, I saw a couple of hands, third up but didn't finish. Did you want to

put your hands back up?

MR. DUDLEY: Jim Dudley with Paralyzed Veterans.

The bill refers to three pilot managed care programs. For the purpose of this contract, how do you define managed care, and what would the contracts be bidding on? What is your definition of managed care? And what would you expect these folks to be bidding on?

MR. LOPER: I think Dr. Perlin went to some effort to distinguish the phrase, managed care, from care management.

And he would wish us to – it's more than semantics in his view. Managed care implies sort of a constellation of practices and procedures and strategies that have been extant probably for the last 15-20 years. Then care management he sees as a breakthrough kind of perspective that says, all things could be brought to bear, but it is about care management.

And so I think he intends something different than what is typically thought of with managed care. He would seek value added performance-based outcomes-oriented management of care among veterans, not the implementation of managed care

strategies for managed care benefit; if that makes sense.

Is that responsive, Jim? That's a little tough to answer, what does Dr. Perlin mean by managed care. But I think again it goes to the distinction to step away from what has conventionally been thought of as managed care.

MR. DUDLEY: I heard what he said, and I was still kind of confused on what it means. If you are talking about a full range of medical services, everything from primary care to some specialty care, is that what you are talking about? Or are you talking about just selected areas that may assist the VA in managing the overall care needs of veterans?

MR. LOPER: I'm sorry, I'm just trying to process the question in my mind.

I think what he would do is approach a participating network with a platform of opportunities to improve care outcomes, continuity and service.

The strategies deployed, or employed, in that process, if you mean networks claims processing, referral management gatekeeping, right of first refusal, all the things sort of conventionally associated with managed care, need not occur in his

mind per se to get to the outcomes he's after.

So he is writing care management very large, and it is not how do we apply traditional managed care techniques to the VA population.

Anybody got a better way to get at that, I guess I'm supposed to be the one answering these questions. That's the best shot I could do, Jim. I'm happy to explore that a little bit more with you at your leisure.

Yes, please.

MR. BRADLEY: John Bradley.

How much money are you going to spend on this?

MR. LOPER: Great question. Comes up all the time as it should This being passed in I think it was sort of carefully pointed out in report language, not as an appropriate per se. There is no specific amount associated or appropriated for this purpose.

The – and as I said to the steering group this morning, if you are talking about a net cost, in theoretical terms, this is intended and envisioned by many or most to pay for itself.

Having said that, we are probably months to some short years away from being able to cover

administrative costs, I suspect. We have asked for startup money in relatively small amounts to do the staff work, and the support contractor components of demonstration development.

But I guess the examples I would use, I shared with you the four baskets of work if you will that are organic to this demonstration. The easiest case to narrate, I think, is the revenue support piece, which by common prevailing current practice, in most applications, our partners are only paid a share of collections.

Therein, it costs us nothing to the extent that they enhance our collections, and they get a share of it. If they get eight percent of net return, we get 92 percent, it costs us nothing. If in health services integration, we find components of the population or conditions or whatever for which there is a business case that saves $10 million on a network for a specific component of care, if it's structured such that there may be an administration cost plus a share of recovery, then it costs – well, it costs us the administrative costs, maybe, and it's a share of recovery, the government care of recovery is substantial it will cover the administrative costs.

There are probably some costs in the community optimization piece that says, okay, if you've got to go out and build some community capacity – contract network, whatever the solution that's offered might be – there are administrative costs potentially with developing and operating and administering that.

To a certain extent I would submit that we are incurring those costs today to the extent that we have a cottage industry negotiating local contracts with providers, in sometimes some pretty unsophisticated ways on what is common some pretty poor terms.

So I am hopeful that the marginal cost to the department to get us a quality capacity in the community will more than pay for itself.

And if it's not, then we may have to redesign it. And the last case is probably VHA optimization. Therein again, subject to the ability to define performance levels and to discern accountably contractor performance, if we can increase in an entire network the capacity of the system by eight percent, and reduce purchase care to effective management by 15 percent – I'm making that up – then that increased capacity is more veterans we

see in our system, and a decreased unit cost, and the vendor may receive a share of that improved performance.

Another contracting model would simply say, we want some staff assistance. We want on a cost basis some additional capacity, and we will pay an administrative cost for that. And that's administrative service only; then it'll cost us.

But there again, if the business model is, we are willing to pay that administrative cost, in exchange for additional internal capacity, and clinical production, or reduced waiting lists and less purchased care, then I'd submit that there is a business model that says it can pay for itself.

So how much is this going to cost? Some amount for administrative costs during startup, and then I'm hopeful it will be more than compensated for in the value of care under a properly care managed concept.

Is that helpful? The appropriators did not give me a budget for this, or give the department I should say; certainly didn't give me one. Did not give the department a budget for this, but they gave us the latitude to design a cost-effective solution.

I would submit at the end, if we can't

deliver a cost-effective solution it will have to be altered in some significant way.

Another question?

MR. HORBILL: Yes, thank you. My name is Anthony Horball. I'm a Medicaid contractor from Pennsylvania. I'd like to ask you, given the previous question, if you're not able to tell us the budgeted amount or the allocated funds, might you share with us what is the current number of individuals served – I saw something, five million – and what is the cost of serving that number of veterans in the system?

MR. LOPER: I think I better take that for the record. I don't have that on my hip here. And maybe we'll answer that on the FedBizOpps. I'd want to get a fairly specific phrasing of the question so I understand it.

But we spend a little over $30 billion for 5.3 million annual users, but we do also support research and education within that construct.

MR. HORBILL: I understand. $30 billion for 5 million. Thank you very much.

MR. LOPER: Okay, great. Yes, sir?

MR. COWELL: Yes, Mark, it's Fred Cowell from the Paralyzed Vets, trying to follow up on that

care management reply you gave to that question about managed care.

Would that be care management for specific diagnoses?

MR. LOPER: I'm sorry?

MR. COWELL: Would it be care management for specific diagnoses that might be available to this audience to carve out certain specific illnesses to provide care for those individuals? Are we talking about medical care delivery here?

MR. LOPER: We are talking about medical care delivery, which is what this entire effort addresses.

MR. COWELL: Right. What are the types of medical services that you would expect these people to provide?

MR. LOPER: There is no reason to think that this demonstration would alter the scope of care contemplated. Programmatically there is no intended effect on the scope of care provided by this. In each case it would seek strategies to improve care across the board, or in - I guess as the health service integration piece would say - high value opportunities to make it better.

And so we would look to basically this

whole thing is to put a platform of opportunity at the hand of network directors, monitored clearly by Dr. Perlin's central office, through as you know his – what did he say? – his measurement compulsion or obsession, to monitor performance, to improve care management across that network.

MR. COWELL: I think I get that part. But would these providers be required to provide the full benefit package that VA guarantees to veterans, or a piece of that?

MR. LOPER: I think it is appropriate to say, this demonstration in now way alters the benefitg. Period, end. This basically puts tools at hand to the managers of the enterprise to meet and satisfy that benefit more effectively. That's all it does.

You know there is this sort of persistent question that is outsourcing. I have said it is characterized I think fairly clearly I believe that it is insourcing. We are not authorized to alter the benefits. There is nothing in the appropriations or authorizing act that changes the benefit in any way. So we're not provided to do that demonstration authority does not amend our obligations in that regard.

We believe, as I think Dr. Perlin alluded to, there are opportunities to improve the care that we provide. That's what this is.

And I guess, to whatever extent someone might persist with a perception that this is – and I've heard it said, and we'll just put it out there – that this is a system parallel to the VHA, okay, sometimes it's hazardous to answer a question that hasn't been raised. It's not a parallel system to the VHA; it is the VHA. It is like you have Quicken at home to help you manage your checkbook. You're still managing your checkbook; still have the same income; still have the same obligations. You have a tool to help you better manage your checkbook. That's basically what this is.

So there is no sense that a beneficiary or a veteran has to disenroll from the VA and enroll in this demonstration. It is the VHA, and so if anybody is struggling under that misconception, I would certainly wish to alleviate that one.

Yes, Ray.

MR. FRIAR: Ray Friar. This schedule is very helpful. I'm having a hard time plotting dates, but I think the answer to your last question was, it's going to complement the VA system is what

you're really saying. Where you're having to purchase care, you want something to complement but not be different than what you're currently delivering.

Data is always an important attribute in trying to come up with a solution. How much data and when in this process would one be given data I guess is the principal question I would have.

As you know we spend a significant amount of time looking at data, analyzing data, trying to use that as a tool to solve a problem. It's not the only tool one uses, but certainly a very important one.

MR. LOPER: This is a very important question. I appreciate as well the sort of clarification and assistance there.

We have made provision in a sort of a straw man procurement schedule – certainly I have done that – for an entire data collection period. We have some special organic services, a Veteran Service Support Center, VSSC, who does extensive and deep analyses for us. We are a data rich environment.

I don't wish to convey however a scatter diagram of data. I would submit that when we define and adopt a set of objectives, and propose a set of

measures associated with engaging our performance in those objectives, determine what the objectives are in the contract so we understand parameters and expected contractor performance, then the data requirements will become clear.

If there is some omnibus data in the meantime that would be useful for us to post, I'd be happy to take your suggestions in that regard.

MR. FRIAR: I would like to suggest that possibly if you have an area that you want to proceed in, if you have data you can supply, that may help in setting objectives as to where you would want to go.

Critical mass will be important. Some of those things will be important as to where you can bring resources or assets to bear.

So would ask your indulgence to get some of that kind of data that would help us.

MR. LOPER: Thank you, Ray, and we'll certainly take that suggestion.

I also had somewhat hoped to be able to announce the demonstration sites today. Can't quite get there yet, but we're close, and that will be clear soon, then the scope of the relevant data becomes a little more clear as well.

Bob.

MR. BRAULT: Yes, Bob Brault. Would you share with us the participants in this session, at FedBizOpps announcement?

MR. LOPER: Yes we intended – and I hope no one would object to posting the attendee list on the web.

Yes.

MR. SCHOSSLER: Second question from Navigant. Is this initiative in any way an outgrowth of CARES, the CARES initiative? Is there any relationship?

MR. LOPER: Not that I know of. You know, someone who has been in VA longer than I may seem some relevance, but it is not CARES 2.0 or anything like that.

Are there some data from the CARES study that might be informative? Maybe. Maybe it's two data now, I don't know.

Yes, ma'am.

MS. BARD: Julie Bard with 3M. Quick question. Would you please expand on this initiative as it relates to the national initiative on data standards and interoperability and how that will relate to the strategic vision that Dr. Perlin laid out and the concepts that you want to see?

MR. LOPER: I would love to. Is there somebody here smarter than me? I'm sure there is a roomful of them. Can we record that question? I'll need some help on that. And we have your business card and registration.

I guess the response then gets published, as I understand the rules. So thank you for that one; I wish I knew.

Any other questions? Yes, sir.

MR. CHAULDRY: Shoby Chauldry from Grant Thornton. Quick question. You mentioned that this program be rolled out across the different VISNs and VUV level as a sort of an options for the network, the VISN networks.

Do you envision any sort of incentivizing for the network directors to avail of these things as they go live? In terms of performance targets particularly towards this program?

MR. LOPER: Let's see, there are provisions that I think Lynn mentioned for proliferation of practices as it is appropriate to do so. The contract platform I think you could put in place would be an enabling of rapid proliferation. All the operations are subject to continuing

performance evaluation as we know that.

Let's see what else? The other part of that question. And all this is being briefed regularly to the national leadership board of governance, the business leadership, and Dr. Perlin, and it will be even more so as we go forward.

So I'm not sure if that's entirely responsive. If you're speaking to whether other network directors can pick up options on this stuff?

MR. CHAULDRY: If there is going to be any specific incentives for medical directors to avail of some of the services, contract services, under this program?

MR. LOPER: I would imagine we have the flexibility to do that, and one of the last things I'd wish for is if the demonstration had the effect of retarding advancement in other locations.

So if we learn something along the way, I'd wish for us to take advantage of it. We will be mindful as well of our accountability through performance evaluation, and as we look for someone to do an accountable evaluation, there is mention, and I've certainly had a notion, of the need for control sites, sort of somewhat an uninterrupted, unperturbed parallel environment that could be used as internal

benchmarks.

The data business that Mr. Friar mentioned, and this question, sort of suggest to me that the baselining is critical so that in the evaluation we can actually discern whether it was the demonstration itself that was responsible for any improvement, or if it would have happened even without the demonstration.

So what is attributable to our partner's performance, our collective performance, in the demonstration model? And what might have happened anyway?

But I think we will secure and preserve the latitude to take that action, if that makes sense.

DR. KRAKOWER: Jack Krakower, AAMC. Dr. Perlin and yourself and other members on the podium mentioned the role and importance of academic medicine in our teaching hospitals in the delivery of and provision of health care to our veterans.

What provisions are being made in the evaluation process to incorporate the views of academic medicine in the assessment of the contract negotiations?

MR. LOPER: That's a good question. I

mentioned we are – when I consider we are about 20 percent designed, I certainly feel that's a little bit optimistic. We're probably still at about 10 percent design.

Our governance model is being put together. But we recognize this special mention and provision in the law with regard to our association with affiliates, and we'll make special provision for that in the advisement of the design.

Other than that, the evaluation, actually we have two senior staff members, both physicians, and our acting chief officer for affiliations involved in the design and evaluation regime, so I think that will be well contemplated, if that is any comfort to you at this point. That's a shape in the fog at this moment.

Mark?

MR. BACON: I want to be able to state, or if you would state this for me. Exactly what is the problem or the state that you're correcting in terms of – because I'm hearing moving – well, getting maximum capacity, or moving people into the facilities, and your fee box, I assume. I guess what problem, optimal health care, or reduction in costs? Or the less contracting? What is it that is the kind

of broad objective of this?

MR. LOPER: I guess if you are saying, why are we doing this? What problem are we trying to fix? Well, I mean, one, the law certainly, there is a growing body of interest that we should do something. I think it depends, where you sit is where you stand. There is a certain aspect that we could serve veterans better; that access could be improved; I think there is also a tech push and a requirements pull component to is.

Tech push means there is opportunity that we've seen that could be brought to bear in service to veterans. And the requirements pull at least includes the experience of double digit 50 percent range type of increases in single digit years in purchase care costs.

So that's clearly a driven. When contract hospitalization goes up roughly – I think it went up 62 percent in two years – how much of that – well, one, that growth rate can't be sustained. And you could attempt to get a better price on contract hospitalizations, but that is probably not what is responsible for that degree of growth in our estimation.

So we have to look at ourselves as well.

So there is clearly a cost feature. There is a service feature. There is an access feature. And I would submit there is probably also a quality feature, which is what is behind driving the virtual connections and interoperability with community providers.

You know in many many cases every day, you tell a veteran they need a certain test or evaluation or something, and say, go find a doctor and send us the bill.

And so they go see a doctor, and they send us a bill, and we get a paper bill, and it sits in an office until we can get to it and try to adjudicate it. We don't pay it promptly. We tend to lose good relationships with providers if we don't pay promptly. We don't pay precisely.

And we don't collect third party revenue opportunity from that. So Dr. Perlin has sort of said in other venues, we are excellent at clinical and we're not so excellent at business. So certainly behind that is an opportunity to develop the business component. The right brain and the left brain in the VHA enterprise, and to leverage again this capability on behalf of veterans.

Is that responsive, Kevin? I mean there

are a lot of reasons. Those are among them.

MR. EDWARDS: Jim Edwards with 3M.

MR. LOPER: Hello, Jim.

MR. EDWARDS: I may have missed it, but I didn't hear a timeline of how long the demonstration project would be scheduled to run for? And while the demonstration projects are running in selected VISNs, will the other VISNs as you stated it discontinue to use this cottage industry of negotiating contracts with providers who are providing care in the field?

MR. LOPER: I guess it – did you ask me the duration of the contract?

MR. EDWARDS: Yes.

MR. LOPER: Okay, my perspective, and I briefed it, and it's not been corrected per se at present, is on the order of three to seven years. But that has everything to do with the business model, the level of capitalization our partners have to endure.

You heard Dr. Perlin talk about a strategic partner. We don't want a quick hit, by and large, somebody to join us, take a look at a few things, and walk away. If they have reasonable expectation they are going to be with us for awhile,

they will capitalize, they will invest, we'll get intellectual capital and assets, so myself, I intend to go to a – I would wish to go toward a seven-year end.

Having said that, as we put the objectives together and in terms of what that scope of work would entail, if there is reason to think that substantial improvements can be achieved in a much shorter period of time, in other words there are some real quick hits here, then I guess I could be persuaded it's toward the three-year end, take the lessons and recompete.

So and then I think I'd like to echo something that was said from the acquisition community, which is, the duration anticipated in this piece of work might actually come as a byproduct of a proposal from the offerors. They'd say, we'd really like to do this kind of work, but we don't want to do it for three years. It's not economic for us. We can't bring our intellectual capital to you over a three-year term and make any money.

That actually has to be a feature as well, and I think that does justice to what you said. So writ large, to meet Dr. Perlin's objectives on care management, the most valuable proposal is a

three-year one or a seven-year one; we'd have to contemplate any such. That's a frankly honest answer to that one.

And I guess the other was the sustainment of the words I'll regret regarding cottage industry. We don't intend to perturb other networks who are not party to this under the auspices of this. Network directors are free to adjust their own operations.

And in visits I've done to the field, I have encountered many pleas for more sophisticated procurement of community providers. When we go talk to parties in the community, we don't know half of what we need to know in our negotiations, and we're not sure we're getting anywhere near what we ought to get as a consequence of that.

So if we what we can put in place is a capability that in the context of the demonstration delivers adequate numbers and varieties and qualities of providers in this setting, and for the 25 cents, go over and do it over here, we'd probably be foolish not to take that piece, and also apply it over there.

Having said that, that would be extramural I think in terms of the definition – the demonstration. Does that make sense?

Dave.

MR. BAKER: Thank you. Dave Baker, Humana Military.

Mark, one of the themes that I'm hearing here is focused around the why and the what are you trying to accomplish, and really focused on the objectives. At one point in your remarks today, I think I heard you say that you were looking for input from industry and academia in the development of those objectives. And then I see on the chart that there is something that is not exactly a request for a proposal, but a request for solutions, which implies that you're going to at some point crystallize what it is that you intend to achieve.

And I'm struggling a little bit in terms of our purpose here, and that process and timing of developing the objectives. Can you help me out?

MR. LOPER: Okay, yes, I will attempt that at any rate.

The law would say that we had 90 days to submit a set of objectives. Frankly it occurs to me sometimes, spontaneously, that the secretary could say in fact, here are my objectives as of today, and three weeks later, change them.

I doubt that he would wish to do that,

and so we'd like those to withstand the test of time, and be as enduring as possible.

This particular meeting that regard – I sort of tended to allude to as, one, we just wish to let industry know what we're thinking about sooner rather than later, and this is the first point we've come to anything reasonable cogent to share that made any sense.

The particular deliverable, I guess, with this regard, this is both principally a broadcast of what we wish to do, but specifically a request or solicitation of input. We've gone further today actually than we thought we might with respect to questions. We did not wish to solicit everybody's questions, end up with 3,000 questions, and go off into the dark answering questions instead of developing what it is we're trying to buy.

But I think we've done okay in that regard. Bu this was to gain whatever near term input we might from industry and academia with regard to the phrasing, content, scope and ambition expressed in the objectives.

And so I would wish at the earliest date, frankly, it will help me very much as we go back to our representatives in Congress and their

staff and say, we are attempting to fulfill our obligation to collaborate with industry, one that we enjoy, by the way, to fulfill that obligation with regard to the formation of the objectives.

And we have solicited input and received input, meaningful input, from industry and academia that these objectives are cogent; they're comprehensive; they're aggressive; they're ambitious; or they're trivial, and they need a little bit of adrenaline, or what have you.

Then I could look also Secretary Nicholson in the eye, which I guess I'll get to do next Thursday, and tell him, we've got some input, and these are the set we proposed here.

So that and then I believe we also on FedBizOpps put out a set of questions in advance. That's like we did at a prior meeting. Here are a set of questions that we would enjoy receiving input from industry on. Those are posted I understand at FedBizOpps, probably, and there is a hard set copy of the questions evidently outside.

So if there are any of those in which you think you have particular interest, competency, perspectives, a contribution to make, that is probably a little less timely than the objectives

are.

I would say, what are we here, within the next three to five days, feedback on the objectives could influence their statements. So please do that.

And that's why we're here, I guess. As soon as possible we'll have something to share and to fulfill the collaboration requirement.

MR. TERRAZAS: Ted Terrazas with TerraHealth. As you were speaking, one of the things I started jotting down as some notes, and in some of those notes I came up with some ideas which we can provide to you.

But of course as industry we're very careful of what we might submit. We may also see our solution being proposed back to us, and then as nonunique.

So what I think I hear you saying is that what you would like to see us do is propose some business and care models, those models with objectives that will be provided to the Veterans Administration that are more efficient, and some of those that are even a zero sum game where they can bring some efficiencies and effectiveness to the Veterans Administration, hold off our solutions until

the proposal with our team and with specifics with regard to the magic that we can make it work.

The question I have really is that in our proposal you did say that there would be – this is not changing the system, and you are not looking at outsourcing. However, efficiency and effectiveness does tend to lead to some consolidation and some economies of scale.

Is that fair game? Whereas some resources, some individuals, FTEs, let's say for example, may be surrendered?

MR. MALONEY: I think that is a question that we have to wait until we get the proposals out, or have a question and answer period. I think that's a little leading at this point in time.

MR. CHAULDRY: What do you envision are the major cultural transformation challenges around this effort?

MR. LOPER: Cultural transformation challenges? Okay. Well, certainly one that comes to mind for me, it's not specifically cultural, but it is about communication, this is a complex enterprise. And it is difficult to communicate what the intent and effect of this is. And that complicates cultural change, frankly.

The cultural change here that I think we should, or would, anticipate or wish for, is one toward enhanced quality outcomes in care management. And I think the proliferation of performance measurement, objective outcome performance for veterans, better service to veterans.

So cultural change? It's kind of like taking the ACT orals, only tougher. I think we wish in this whole process to sort of honor the traditions associated with serving veterans, to honor our obligations. The culture is to sustain the statement by President Lincoln in that regard, and just to begin to import, and allow other citizens in this country actually to contribute intellectual value and processes and business strategies to make this enterprise better.

And as a byproduct of making it better, advance our nation's health care.

Cultural transformation, potentially a little more business orientation, as a supplement or complement or in fact as organic to the provision of care.

If that answers your question.

DR. KRAKOWER: I hope I'm not misquoting you. I think a few minutes ago you said you needed

to be able to assure Congress that you had received meaningful input from academia and industry. And then a few minutes later you had a very short timeframe for gathering suggestions for folks like this.

What provisions are you making to make sure you get meaningful input from academia?

MR. LOPER: Okay, good question. One is the short time frame I would allude to is with specific regard to the set of objectives that the secretary holds. The acquisition process, the objective setting relies on a fairly extensive component of market research. And until I'm told, as I understand, that until the RFP is actually issued, which we are some months away from, we are free to dialogue with industry and academia.

Now having said that, to have a stream of 150 companies coming through the office, I mean I understand and am told we reserve some latitude to sort of filter, focus something, target, within an appropriate value-added market research strategy.

This will go on through to the point of RFP release, and potentially – I mean I hope we don't go through a best and final process, but if we go through a best and final there will probably be

another subsequent opportunity.

But we have – you know, we have until May-June-July to issue the RFP. We have some months to collaborate and communicate.

VOICE: (Inaudible)

MR. LOPER: As a matter of fact, I understand Dr. Karen Sanders issued such an invitation to WMAC two days ago. And that was the first step, first basically telling them that we were free to share whatever draft objectives we had.

And she will probably be our conduit to a degree, in that specific regard. But again, I believe the dialogue, the opportunity for dialogue, will endure for months, specifically with regard to objectives. We'll take your input any time, but if you want true consideration of them, the sooner the better.

Okay, any other questions?

MR. BAKER: Mark, I'm sorry to return to this, but the – again, trying to integrate the input from industry and academia with some of the earlier comments. I thought I heard you had a requirement to go back to the Congress by the 28th of February with your objectives.

Is that not --

MR. LOPER: Yes, we – the secretary owes his expression of the intended objectives by 28 February.

MR. BAKER: And at some point after that, you will issue a request for solutions. And so I judge that it is that interval between the statement of objectives, and the request for solutions, in which you will be inviting input from academia and industry? Is that a fair statement?

MR. LOPER: I think that is a fair statement. To whatever extent that might be contradicted by our requirements development teams, or our proposal teams, to further scope those objectives to a slightly more granular level, that may contract that sort of exchange period, but I'm not sure why we need to. I think we're free to dialogue.

MR. BAKER: But conceptually, I think --

MR. LOPER: Conceptually you are correct, I believe.

MR. BAKER: And I think you were also asking for input at the front end, in the development of the objectives.

MR. LOPER: Correct.

MR. BAKER: But if you have until the

end of the month, there is some point at which you have to say, thank you very much, but this is when we have to cut off the input.

MR. LOPER: With regard to the objectives?

MR. BAKER: With regard to the objectives.

MR. LOPER: So the global, if you will, the global sort of demonstration objectives, there is absolutely a sunset on that.

MR. BAKER: And I also think I heard you say that you'd like the input as quickly as possible, but many of us work multiple projects, and I would encourage you to define, what is the endpoint when you need our input? We got your draft objectives. Be happy to provide input, but I don't want to spend a whole lot of time on it if I miss the gate, if you understand where I'm going.

MR. LOPER: This is a huge organization we're part of, and I guess what I would wish to offer is, as much time as possible. Having said that, the secretary has said to have those objectives up to me by what, the fifth or something. And then we asked that that be postponed, so we can at least get beyond this interchange, and so I think, I'm happy to send

them – I'll send them a set and I'll send them a revised set to buy us a little more time, but we can't buy a whole lot of time in that process.

So date certain, somebody get a calendar. Now you know by – they would wish me to clarify or make a distinction between these six global objectives, and the statement of objectives yet to be developed if you will for each of those baskets of work. That work begins in earnest in February.

The ones that we seek your comment on are the six global demonstration objectives, and you know that, you recognize that.

MR. BAKER: I thought that was the case.

MR. LOPER: So here we are at the second – I don't know whether we ought to negotiate on it, I'd love to.

MR. BAKER: No, I'm just encouraging you to establish and communicate whatever the timeline is that you would like to --

MR. LOPER: As soon as possible, immediate – a week from today.

MR. BAKER: Okay, thank you.

MR. LOPER: That's fairly arbitrary, and puts me a little at risk, but that's all right.

But again, is this the right set? Is it not sufficient? Is it too ambitious? I'd just wish you to – or if you have alternatives, it'd be of great interest.

I don't expect you to do the data measurability studies and all of that sort of stuff. We just want to kind of get the right direction.

Yes, ma'am.

MS. KENNY: Hi, Pat Kenny with Maximus. So for the industry dates, as well as the academic dates, they will all be announced on FedBizOpps, the consultation with academia, I'm not sure who was speaking to that, but I just want to make sure that the flow of information, everything will come out on FedBizOpps?

MR. LOPER: Yes, everything germane to this will go out on FedBizOpps.

MR. KENNY: Right, because the discussion with academia is – is of interest to those of us in industry as well.

MR. LOPER: Okay, that's a good point.

MR. KENNY: It can't be done in isolation is what my request would be.

MR. LOPER: Terrific, thank you for

that.

MR. KENNY: Thank you.

MR. LOPER: That's a good input.

How long will it take to get this on FedBizOpps? These proceedings? Tuesday? Okay.

Okay, well, maybe we've run through it here.

Well, once again, thank you all for coming. This has been quite an experience, and greater things are yet to come. I am frankly excited about the opportunity. I spent however brief a time in the private sector, not too far from the flagpole, but in the private sector, and see great promise in what could be brought to bear in the federal sector, and greatly encourage creative thought and contribution, and we believe, and I'm so pleased to hear Dr. Perlin espouse, a tremendous opportunity at hand that should be used and leveraged, once again, for veterans, excellence for veterans, value for America.

There is a tremendous opportunity to be on the forefront of that in support of the largest health care enterprise in America.

So with that, thank you once again for your time, and I guess if – I might extend a courtesy

invitation to the members of the VSOs to remain after, if they'd wish 20 – 30 minute visit.

With that, we're dismissed. Thank you.

(Applause)